

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-041414

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 373 Primary Registration District No. 6268 Registrar's No. 47

**FILED OCT 9 1962**

1. PLACE OF DEATH a. COUNTY <b>WEBSTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>WEBSTER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>NIANGWA MO</b>		Length of stay in 1b <b>24 HRS</b>	c. CITY OR TOWN <b>NIANGWA</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5 MI NORTH</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>WALTER T. MATHIS</b>			4. DATE OF DEATH Month Day Year <b>OCT 4 1962</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-13-1887</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
13a. FATHER'S NAME <b>A. F. MATHIS</b>		13b. MOTHER'S MAIDEN NAME <b>MALENA WALTON</b>		14. NAME OF HUSBAND OR WIFE <b>VIRGINIA</b>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. _____	17. INFORMANT <b>VIRGINIA MATHIS NIANGWA MO</b> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic Myocarditis</b>		
DUE TO (c) <b>Arterial Sclerosis</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from 3/15/62 to 10/4/62 and last saw her/him alive on 10/2/62  
Death occurred at 200 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>A. R. Todd, D.C.</b> (Degree or title)	22b. ADDRESS <b>Marshfield, Mo.</b>	22c. DATE SIGNED <b>10/8/62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>10-6-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NIANGWA</b>	23d. LOCATION (City, town, or county) (State) <b>NIANGWA MO</b>
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24. FUNERAL DIRECTOR <b>BARBER EDWARDS. MARSHFIELD</b>	25. DATE RECD. BY LOCAL REG. <b>10-8-62</b>	26. REGISTRAR'S SIGNATURE <b>J. Francis</b>
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(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

OCT 30 1962

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_



Licensed Embalmer No. \_\_\_\_\_

7845

P. O. Address \_\_\_\_\_

W. J. G. 710

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.