

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028798

FILED VS AUG 24 1959

IDED

Registration District No. 128 Primary Registration District No. _____ Registrar's No. 829A

STATE FILE NUMBER

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Walnut Grove</u> | | Length of stay in 1b <u>3 years</u> | | c. CITY OR TOWN <u>Walnut Grove</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Walnut Grove Twp.</u> | | | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>CATHERINE</u> Last <u>MATTHEWS</u> | | | | 4. DATE OF DEATH Month <u>AUG</u> Day <u>1</u> Year <u>1959</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>NOV 5 - 1872</u> | |
| 9. AGE (last birthday) <u>86</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (City and state or country) <u>MORRISVILLE - Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>MILTON BROWN</u> | | 13b. MOTHER'S MAIDEN NAME <u>ELIZA HOWSER</u> | | 14. NAME OF HUSBAND OR WIFE <u>JAMES WILLIAM MATTHEWS</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT Address <u>O.C. MATTHEWS - WALNUT GROVE - Mo.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis - exhausting state</u> | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 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 <u>July 22 - 59</u> to <u>Aug 1 - 59</u> and last saw her <u>alive</u> on <u>July 27 - 59</u> Death occurred at <u>6:00 p.m.</u> on the date stated above, and to the best of my knowledge from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>H. H. H. H. H.</u> (Degree or title) | | | | 22b. ADDRESS <u>Morrisville Mo</u> | | 22c. DATE SIGNED <u>Aug 10 59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>AUG 4 - 59</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Walnut Grove - Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>Brown - Daniel - Walnut Grove - Mo.</u> | | | | 25. DATE REC'D. BY LOCAL REG. <u>8-17-59</u> | | 26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u> | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Ray E. Ireland

Licensed Embalmer No. 5052

P. O. Address Stalwart Inn

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.