

FILED JUN 6 3 1942

Registration District No. 63

Primary Registration District No. 1002

Registrar's No. 2015

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Lukes Hospital  
(If not in hospital or institution, write (street) number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community 1 day years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Pottawatomie  
(c) City or town Blue Rapids  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.F.D. (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CECIL MATTERS.

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex MO 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Audelia Mattero 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Nov 30 1893  
(Month) (Day) (Year)

8. AGE: 48 Years 5 Months 24 Days If less than one day hr. min.

9. Birthplace Blue Rapids, Kan. (City, town or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Fruit Farmer

MOTHER FATHER

12. Name Henry A. Mattero

13. Birthplace Washington Co. Iowa (City, town or county) (State or foreign country)

14. Maiden name Paula Louise

15. Birthplace St. Marys Kansas (City, town or county) (State or foreign country)

16. (a) Informant Henry A. Mattero

(b) Address Blue Rapids, Kan.

17. (a) Removal (b) Date thereof May 25/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Rapids, Kan.

18. (a) Signature of funeral director F. C. Heising

(b) Address Kansas City, Mo.

19. (a) 5-24-42 (b) M. M. Crow  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 day 8 hour 30 minute A.M.  
year 1942

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic & acute cardiac failure.

Due to etiology undetermined

Due to pending further investigation

Other conditions (Include pregnancy within 3 months of death): \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy dehiscence w/pt. Marked degeneration of chest. Myocardial hypertrophy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? (City or town) (County) (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? (Specify type of place) \_\_\_\_\_ (e) Means of injury 0

23. Signature F. C. Heising M.D. (M. D. or other) \_\_\_\_\_  
Address St. Lukes Hospital Date signed 5/24/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Frank A. Disney*

Licensed Embalmer No. 3122

P. O. Address Kansas City, Mo.

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. 309

Primary Registration District No. 1002

Registrar's No. 2015

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town.....  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Cecil Watters

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 8/14/42 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

19. MEDICAL CERTIFICATION  
20. DATE OF DEATH Month May day 24th  
year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;  
that I have seen him..... alive on....., 19.....,  
and that death occurred on the date and hour stated above.  
Immediate cause of death Chronic & Acute Cardiac Failure Duration

Due to Exhibition of chest continued opening  
cutting lowest rib box

Due to Mechanical pressure from chest  
deformity

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy Dil. of Heart, Marked deformity  
of chest, myocardial hypertrophy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?..... (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place)  
(e) Means of injury.....

23. Signature..... (M. D. or other).....  
Address..... Date signed.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTARY

93E

1942  
S-17213