

FILED SEP 30 1946 STANDARD CERTIFICATE OF DEATH

State File No. 29612

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1086

1. PLACE OF DEATH:

(a) County BUCHANAN
(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
MISSOURI METHODIST HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 hrs
(Specify whether
In this community 8 HOURS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DEKALA 32
(c) City or town OSBORN (RURAL) 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME HELEN SUZAN MATTER

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

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

7. Birth date of deceased SEPTEMBER 26 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 8 hr. min.

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

10. Usual occupation infant

11. Industry or business _____

12. Name OLIN MATTER

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

14. Maiden name HELEN CHINE

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

16. (a) Informant OLIN MATTER

(b) Address OSBORN, Mo.

17. (a) Removal (b) Date thereof 9/27/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rippsville Cemetery

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

(b) Address [Address]

19. (a) Sept. 27, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26 year 1946 hour 5 minute 50 P.M.

21. I hereby certify that I attended the deceased from 9-26-46 to 9-26-46 that I last saw her alive on 9-26 and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis (ATELECTASIS)

Due to _____
Due to Postmature Birth

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

Major findings: Of operations 159
Of autopsy _____

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 [Signature] (M. D. or other M.D.)
Address St. Joseph Mo Date signed 9-27-46

Duration

8 hrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

28448

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..... *J G Lyons*

Licensed Embalmer No. *952*

P. O. Address *Stewartville 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.