LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

20743

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

ACE OF DEATH
unty Jasper — Registration District No. 411 — File No.
wnship Galena — Primary Registration District No. 2002 — Registered No. 298
y Joplin (No. 1202 Furnace St. Ward)
LL NAME Walter Lee Stinnett
) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
	B	married

MARRIED, WIDOWED, OR DIVORCED
USBAND OF
R) WIFE OF Susie Stinnett

E OF BIRTH (MONTH, DAY AND YEAR) Mch 1 1894

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
30	4	14	

UPATION OF DECEASED
) Trade, profession, or rticular kind of work laborer
) General nature of industry, siness, or establishment in hich employed (or employer)
) Name of employer

THPLACE (CITY OR TOWN) Ark
STATE OR COUNTRY)

NAME OF FATHER Tom Stinnett

BIRTHPLACE OF FATHER (CITY OR TOWN) Texas
(STATE OR COUNTRY)

MAIDEN NAME OF MOTHER Lettie Coker

BIRTHPLACE OF MOTHER (CITY OR TOWN) Ark.
(STATE OR COUNTRY)

NFORMANT Tom Stinnett
Address) 1124 Hill St Joplin

ILED 7/17 1924 A Benson Clark
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 15 1924

17. I HEREBY CERTIFY, That I attended deceased from ....19.... to ....19.... that I last saw h.... alive on ....19.... and that death occurred, on the date stated above, at 5-30 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Gun shot wounds of head - Homicide

1/3 (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) 1/3 (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Perry K Hurrent Coroner M. D.
July 17 1924 (Address) Joplin Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Fairview Cem	7-18- 1924

20. UNDERTAKER	ADDRESS
Heulbert Lead Co.	Joplin Mo.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and St

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17. I HEREBY CERTIFY, That I attended deceased from ....
....., 19....., to .....
that I last saw h..... alive on....., 19....
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUS
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUIC
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