

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

Do not use this space. ✓

19791

1. PLACE OF DEATH.

County Jasper Registration District No. 411
 Township Joplin Primary Registration District No. 2017
 City Joplin (No. 1720 West) St. W Ward

2. FULL NAME

(a) Residence. No. 1720 West St., Ward. (If nonresident, give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 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) Aug 29, 1930

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
—	—	9	16	—

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employee) _____
 (c) Name of employer _____

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

10. NAME OF FATHER W. J. Guinn

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

12. MAIDEN NAME OF MOTHER Frances Mary

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

14. INFORMANT Wm J. Guinn
 (Address)

15. FILED 6/16, 1930 A. Benson Clark
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 14 1930

17. I HEREBY CERTIFY, That I attended deceased from June 12 1930 to June 12 1930
 that I last saw him alive on June 12, 1930 and that death occurred, on the date stated above, at 5 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

measles
107A (duration) yrs. mos. ds.
 CONTRIBUTORY bronchial pneumonia
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

21. WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Edith Wood, M. D.

(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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

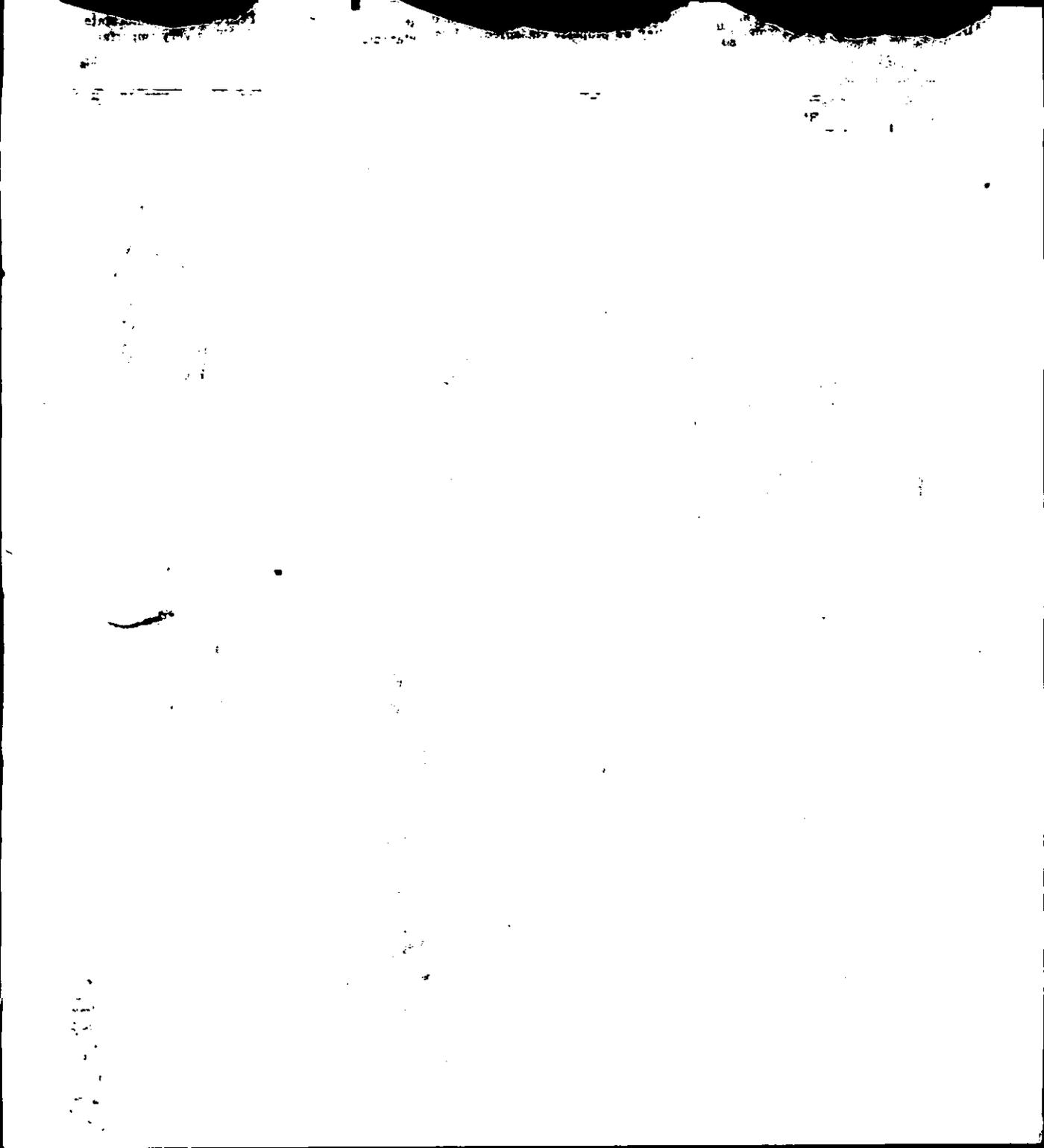
Gen of Mem. Park 6-16 1930

22. UNDERTAKER

Hubert St. Joplin Mo

CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN'S statement of OCCUPATION is very important.

60023 1930



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Jasper Registration District No. 411 File No. 19791
 Township Joplin Primary Registration District No. 2002 Registered No. _____
 City Joplin (No. _____) St. _____ Ward _____

2. FULL NAME Wm Jay Quinn
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 29 1898

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>9</u>	<u>16</u>		

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) _____

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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 14 1930

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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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) _____, M. D.
 _____, 19____ (Address)

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
_____	_____
20. UNDERTAKER	ADDRESS
_____	_____

SUPPLEMENTARY

INFORMANT _____
 (Address) _____

FILED 10/27/30 W. Benson Clark
 REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PLACE OF DEATH in place of residence should be stated EXACTLY. Exact statement of OCCUPATION should be given. IF CATEGORIES ARE COMPLETE AS RECEIVED A FEE FOR REGISTRATION IS NOT NECESSARY.

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