

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

Do not use this space.

39791

**1. PLACE OF DEATH**

County Jasper  
Township Joplin Mo  
City Joplin Mo (No. ....) St. .... Ward)

Registration District No. 411  
Primary Registration District No. 2002

File No. ....  
Registered No. ....

**2. FULL NAME**

(a) Residence. No. 2531 Main St St. .... Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 19-1888

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
42 8 15

**8. OCCUPATION OF DECEASED**

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

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

Mo.

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 Mrs. Augusta Jaynes  
(Address) 2531 Main St

15. FILED 12/6, 19 30 W. Benson Clark REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 4<sup>th</sup> 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 22, 1930, to Dec 3, 1930. I last saw him alive on Dec 3, 1930, and that death occurred, on the date stated above, at 3 p.m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Lobar pneumonia  
108

**CONTRIBUTORY (SECONDARY)**

10/10

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? .....

**WHAT TEST CONFIRMED DIAGNOSIS**

(Signed) J. H. Brookshire, M. D.  
672, 1935 (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 Forest Park Cem Dec 6 30 DATE OF BURIAL

20. UNDERTAKER Frank Pierson ADDRESS Joplin Mo

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.

JAN 20 1931

PL 86-360  
State

Pub. Law 86-360

4711

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
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. ....  
 Township Joplin Primary Registration District No. 2002 Registered No. ....  
 City Joplin (No. ....) St. .... Ward)

**2. FULL NAME**

(a) Residence. No. Willard S. Jaynes 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
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) <u>MO.</u>		
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)		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 4 19 30

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

CONTRIBUTORY (SECONDARY) ..... (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)....., 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

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

14. INFORMANT (Address) .....

15. FILED 272 19 31 W. Benson Clark REGISTRAR

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