

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

14924
 Do not use this space.

REC'D MAY 20 1938

1. PLACE OF DEATH

(a) County Jasper Registration District No. 411
 (b) Township..... Primary Registration District No. 2002 Registered No.....
 (c) City Joplin (d) Street No. St. John's Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Majorie H. Webb
 (a) Residence, No. Galena, Kansas. St. Galena, Kansas.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 8 - 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
10 6 25

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. child
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Galena, Kansas.

FATHER 13. NAME William Webb

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Galena, Kansas.

MOTHER 15. MAIDEN NAME Lethia Edwards

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Galena, Kansas.

17. INFORMANT (ADDRESS) Wm. Webb.
Galena, Kansas.

18. BURIAL, CREMATION, OR REMOVAL PLACE Galena, Kansas. DATE 4/3/38

19. FUNERAL DIRECTOR (ADDRESS) Boice Undertaking Co.
Galena, Kansas.

20. FILED 4-6-38 Ed Glazner
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-3-38

22. I HEREBY CERTIFY, That I attended deceased from 1-25-38, 1938, to 4-3, 1938.
 I last saw her alive on 4-3, 1938. Death is said to have occurred on the date stated above, at.....m.
 The principal cause of death and related causes of importance were as follows:

Pulmonary Abscess (Sept)

Date of onset 1/1/38

Other contributory causes of importance: 59
Heart, Melancholy

Name of operation none Date of none
 What test confirmed diagnosis? X-ray; Urinalysis & paracentesis Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) Th. Webb 308 Frisco Bldg., M. D.
 (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.

1 X12064

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STATEMENT BY LICENSED EMBALMER

I, J. A. Schoeneman, Licensed Embalmer No. 3130

hereby certify that the body recorded on the reverse side of this certificate was embalmed by J. A. Schoeneman

Employed by Boiser Undertaking Co. of Galena, Kansas.
No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed J. A. Schoeneman

Licensed Embalmer No. 3130

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.)

STATEMENT BY LICENSED EMBALMER
No. 1. Exact copies of this certificate are to be filed in the files of the State Board of Health and the local health officer.
K. B. - Each copy of this certificate is to be filed in the files of the State Board of Health and the local health officer.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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1. PLACE OF DEATH

(a) County Jasper Registration District No. 411
 (b) Township Joplin Primary Registration District No. 2002 Registered No. _____
 (c) City Joplin (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S.
(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.
10 6 25

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19__

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-3 1938

22. I HEREBY CERTIFY, That I attended deceased from

_____ 19__ to _____ 19__

I last saw h. _____ alive on _____, 19__ Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Pulmonary abscess
~~Non tuberculous origin~~
Non tuberculous

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19__

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) E. E. Mandy, M. D.

(Address) Joplin

308 Park Bldg

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

