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.

REG'D JAN 25 1939

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

43404
Do not use this space.

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. 309 CONNOR 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 65 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Alice G Aaron.
(a) Residence, No. 309 Connor St.
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
FE	W	WIDOW

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF: WILLIAM L AARON.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JUNE 17-1854

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
84	6	0	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. RETIRED
9. Industry or business in which work was done, as saw mill, bank, etc. HOUSE WIFE.
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) ILLINOIS.

FATHER
13. NAME JAMES G JOHNSON.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KENTUCKY

MOTHER
15. MAIDEN NAME NO RECORD.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) NO RECORD.

17. INFORMANT (ADDRESS) Mrs L. J Aaron 309 Connor Joplin Mo

18. ~~BURIAL, CREMATION, OR~~ REMOVAL — PLACE KEOKUK-IOWA DATE 12/18/38

19. FUNERAL DIRECTOR (NAME) HURLBUT UND. Co (ADDRESS) JOPLIN MO

20. FILED 12-17, 1938 E D Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-17-1938

22. I HEREBY CERTIFY, That I attended deceased from 12-14-38, to 12-16-38, 19..
I last saw h... alive on 12-16-38, 19.. Death is said to have occurred on the date stated above, at 12:30 A.m.
The principal cause of death and related causes of importance were as follows:

Myocarditis, Chr., 18 yrs — Date of onset

Other contributory causes of importance: Fract. Rt Hip

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? Accident Date of injury Last Autumn
Where did injury occur? in Illinois some where
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
in home about two yrs. ago
Manner of injury fell in home
Nature of injury fract. Rt Hip

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) [illegible], M. D.
(Address) [illegible], Mo

(Licensed Embalmer's Statement on Reverse Side)

MAR 29 1957

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 Jerry K Hurlbut

Licensed Embalmer No. 959

P. O. Address Joplin 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, above space should be left blank.