

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.

REC'D MAR 20 1939

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

Dr Kuhn.
7336
Do not use this space.

1. PLACE OF DEATH

(a) County Newton Registration District No. 1046
 (b) Township Shank Creek Primary Registration District No. 5810
 (c) City Joplin (d) Street No. R. 2 Box 462 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 50 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. R. 2 Box 462 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 MALE 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 15, 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 0 3

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

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

FATHER 13. NAME Ezra Mabee
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada

MOTHER 15. MAIDEN NAME Roseanna Mahan
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada

17. INFORMANT (ADDRESS) Mrs J M Jackson Joplin, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Cartersville Cem. DATE 2-20-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Lanpheer Holman Joplin, Mo.

20. FILED 2-21-1939 Ed D Jones Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 18 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 15, 1939, to Feb 18, 1939

I last saw h.f.m. alive on Feb 18, 1939. Death is said to have occurred on the date stated above, at 1:50 P.M.

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

Chronic Myocarditis

Date of onset

?

Other contributory causes of importance:

None

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

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? No
 If so, specify _____
 (Signed) J. P. Jackson, M. D.
 (Address) Joplin, Mo.

RECEIVED

District Health Officer No. 6,

District File Number 6-39-299

Date Filed MAR 10 1939

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, F. M.

Jones

, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed

F. M. Jones

Licensed Embalmer No. 2319

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.