

REC'D MAY 18 1939

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

15161
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 411
(b) Township Galesburg Primary Registration District No. 2002 Registered No. _____
(c) City Joplin (d) Street No. St. Johns 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 22 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Louise Howard
(a) Residence, No. 1716 Harlem 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles Howard
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 20, 1916
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
22 11 2
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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) Joplin, Mo.

FATHER 13. NAME John Scheurich
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Newton Co., Mo.

MOTHER 15. MAIDEN NAME Grace Thachter
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Charles Howard
1716 Harlem

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Park DATE April 21, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Thornhill-Dillon
Joplin, Mo.

20. FILED 4-21-39 Ed. J. Jarrett Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from April 10, 1939, to April 19, 1939

I last saw her alive on April 9, 1939. Death is said to have occurred on the date stated above, at 9:30 A.M.

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

Post-Operative shock Date of onset _____

Other contributory causes of importance:
Salpingitis + pelvic peritonitis

Name of operation Perineorrhaphy Date of April 19
What test confirmed diagnosis? Surgery Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no 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) [Signature] M. D.
(Address) 616 Frisco Bldg Joplin, Mo

1376
RECEIVED

District Health Officer No. 6,

District File Number 6-5-39-1107

Date Filed MAY 15 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, _____

David Dillon

_____, or by _____

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

Signed _____

David Dillon

Licensed Embalmer No. 3898

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

15-161
Do not use this space.

1. PLACE OF DEATH
 (a) County Jasper Registration District No. 411
 (b) Township Juplin Primary Registration District No. 2002 Registered No. _____
 (c) City Juplin (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 House Howard
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
 (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.
	<u>22</u>	<u>11</u>	<u>2</u>	

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) _____

FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 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) 4-19-1939

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:
Post-operative shock (Date of onset 134 h)
 Other contributory causes of importance:
Salpingitis + Pelvic Peritonitis
Puerperal Salpingitis
 Name of operation Perineorrhaphy Date of 4-19
 What test confirmed diagnosis surgery. 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? _____
 If so, specify C. N. Outt, M. D.
 (Signed) _____ (Address) 616.7th St. Bldg. Juplin Mo.

SUPPLEMENTARY

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

