DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7569

Registration District No. 1046

Primary Registration District No. 5810

Registrar's No.

1. PLACE OF DEATH:

(a) County: Newton

(b) City or town: Rural (Shoal Creek Township)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1½ Mi. South of Redings Mill
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---------- In this community 10 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Newton

(c) City or town: Rural-Shoal Creek Township
(If outside city or town limits, write "RURAL")

(d) Street No. 1½ Mi. South of Redings Mill
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ---------- years.

3. (a) PRINT FULL NAME: Harvey B. Bean

3. (b) If veteran, name war: ----------

3. (c) Social Security No. ----------

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widower

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive ------ years

7. Birth date of deceased: Sept. 21, 1860 (Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days 3 If less than one day ____ hr. ____ min.

9. Birthplace: Canton (City, town, or county) Ohio (State or foreign country)

10. Usual occupation: Retired

11. Industry or business: Unknown

FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Mrs A. Farmer
(b) Address: R #3 Joplin Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 2-27-40 (Month) (Day) (Year)
(c) Place: burial or cremation: OZARK Mem. Cem.

18. (a) Signature of funeral director: Hurlbut Und. Co.
(b) Address: 212 Joplin St., Joplin, Mo.

19. (a) 2-26-40 (Date received local registrar) (b) Ed D James (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24 year 1940 hour 3 minute 00 A.M.

21. I hereby certify that I attended the deceased from Feb. 20, 1940, to Feb. 24, 1940 that I last saw him alive on Feb. 23rd, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Apoplexy

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations:

Of autopsy:

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: E. B. Thompson (M. D. or other)

Address: Joplin, Mo. Date signed: 2/26/40

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED
District Health Officer No. 6,
District File Number 340-704
Date Filed MAR 8 1940

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 Perry F. Hurlbert

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 75-69

Registration District No. 1046 Primary Registration District No. 3810 Registrar's No.

1. PLACE OF DEATH:
(a) County Newton
(b) City or town Shoal creek (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Harvey B. Bean
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced wd
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased Sept (Month) 27 (Day) 1860 (Year)

8. AGE: Years 79 Months 5 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 2-26-40 (Date received local registrar) (b) Ed N James (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 24 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature W. P. Chapman (M. D. or other)
Address Joplin Mo Date signed

SUPPLEMENTARY