

MAY 13 1940  
Registration District No. 411

Primary Registration District No. 2002

Registrar's No.

1. PLACE OF DEATH

(a) County Jasper  
(b) City or town Joplin  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2006 Pennsylvania  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community

years, months or days 120 120

8. (a) PRINT  
FULL NAME

Infant (male) Samples

8. (b) If veteran,  
name war \_\_\_\_\_

8. (c) Social Security  
No. \_\_\_\_\_

4. Sex M

5. Color or  
race W

6. (a) Single, widowed, married,  
divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased 4-26-40  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

hr. 10 min.

9. Birthplace

Joplin, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name W. F. Samples

13. Birthplace Wash City, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Mabel Stranger

15. Birthplace Joplin, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature

Father

(b) Address

Joplin, Mo.

17. (a) \_\_\_\_\_

(b) Date thereof

4-27-40  
(Month) (Day) (Year)

(c) Place: burial or cremation

Int. Hops

18. (a) Signature of funeral director

Mrs. Hops

(b) Address

Joplin, Mo.

19. (a) 4-26-40  
(Date received local registration)

(b)

E. J. Jones  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jasper  
(c) City or town Joplin  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2006 Pennsylvania  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26  
year 1940 hour 6 minute 58 M.

21. I hereby certify that I attended the deceased from  
4-26-40 to 4-26-40

that I last saw him on 4-26-40

and that death occurred on the date and hour stated above.

Immediate cause of death Baby born by cesarean

Myocardial infarction

Due to hypertension by membranous

kidney failure

Full term -

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) See above

(b) Date of occurrence

(c) Where did injury occur? Joplin Jasper Mo.  
(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 \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature E. J. Jones (M. D. or other MD)

Address Joplin Mo Date signed 4-27-40

40-5-77

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

# MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. ....

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 411

Primary Registration District No. 2002

Registrar's No. ....

## 1. PLACE OF DEATH:

- (a) County Jackson  
(b) City or town Jackson  
(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  
In this community \_\_\_\_\_ years, months or days)

## 3. (a) PRINT FULL NAME

Infant Male Samples

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 \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days (If less than one day, hr min)

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

## 10. Usual occupation

## 11. Industry or business

12. Name \_\_\_\_\_  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal)

- (c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 4-27-40 (b) Ed W. Jones (Date received local registrar) (Registrar's signature)

## 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.

## 20. DATE OF DEATH

- Month Apr day 26 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_; that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## 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?

While at work? (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature P. W. Poor (M. D. or \_\_\_\_\_)  
Address Jackson Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-15166