

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

JUN 10 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

(c) Name of hospital or institution: St. Johns Hospital
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 12 days
(Specify whether years, months or days) 18 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri; (b) County Jasper

(c) City or town Joplin
(If outside city or town limits, write "RURAL")

(d) Street No. 708 N. Byers Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Haidée Schloss ⁴²⁰

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25th
year 1940 hour 14:40 minute _____ a.m.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Jacob

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

7. Birth date of deceased Mar. 8, 1874
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 3-13 to 5-24 1940
that I last saw her alive on 5-24 1940
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

66 2 17 hr. _____ min.

Immediate cause of death Cerebral hemorrhage

Due to Hypertension heart

Due to _____

Other conditions (include pregnancy within 3 months of death) SD

Duration 8 mo

5 yr

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

10. Usual occupation At Home

Major findings: of f. Ca. of breast
Of operations w/ke 6 yrs. ago

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

MOTHER FATHER

11. Industry or business _____

12. Name Joseph Newman

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

14. Maiden name Catharine Silver

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

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? _____

16. (a) Informant's own signature Walter A. Tinger

(b) Address Joplin, Mo.

17. (a) Burial (b) Date thereof 5-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns

18. (a) Signature of funeral director Shambill-Billa

(b) Address Joplin, Mo. 372

19. (a) 5-28-40 (b) _____
(Date received local registrar) (Registrar's signature)

23. While at work? _____ (Specify type of place)

(e) Means of injury _____

28. Signature [Signature] (M. D. or other) MD

Address [Address] Date signed 7/27

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
 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.
 Rev. 6-17-39

40-6-145

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.....

Don Patrick

Licensed Embalmer No.....

4208

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.