

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 711 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: 1816 HARLEM
(d) Length of stay: In hospital or institution 9
In this community 21 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JASPER
(c) City or town JOPLIN
(d) Street No. 1816 HARLEM
(e) If foreign born, how long in U. S. A.?

8. (a) PRINT FULL NAME BEATRICE MARY DYE
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 WIDOW
6. (b) Name of husband or wife CLINT DYE 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased AUGUST 10 1867

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month MAY day 5 year 1940 hour 1 minute -- P.M.
21. I hereby certify that I attended the deceased from Apr. 24 1940 to May 5 1940
that I last saw h. 2x alive on May 5 1940 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
72 8 25 hr. min.

Immediate cause of death Pulmonary edema Duration 12 hr.
Due to several arteriosclerosis
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace HARRISON ARK.
10. Usual occupation HOUSE WIFE
11. Industry or business Home
12. Name UNKNOWN
13. Birthplace UNKNOWN
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy None
Underline the cause to which death should be charged statistically.

(a) Informant H. J. Millard
(b) Address 1816 Harlem
17. (a) BURIAL (b) Date thereof 5-7-40
(c) Place: burial or cremation MT. Hope Cemetery
18. (a) Signature of funeral director HARL BUT UND CO
(b) Address 212 Joplin St. Joplin, Mo
19. (a) 5-6-40 (b) E. B. Jarney

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 372
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Keith L. Hoff (M. D. or other) _____
Address Joplin Mo Date signed 5/6/40

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

75

MOTHER FATHER

40-6-166

CG

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..... *Raymond J. Farrell*

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 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. **18734**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **411**

Primary Registration District No. **2002**

Registrar's No. _____

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

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:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME **Beatrice Mary Rye**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **F**

5. Color or race **w**

6. (a) Single, widowed, married, divorced **w**

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 **72** Months **8** Days **25** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) _____

(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 **may** day **5** 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 **Pulmonary edema**

Due to **General Arteriosclerosis**

Due to **Myocardial degeneration due to coronary disease**

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

Major findings: **ASC**

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) **99**

(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 **Robert L. Neff** (M. D. or other) _____

Address **Joplin Mo.** Date signed _____

SUPPLEMENTARY

