

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. John's Hospital**  
 (d) Length of stay: In hospital or institution **42 years**  
 In this community **42 years**

3. (a) PRINT FULL NAME **Emma M. Shaffer**  
 8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
 6. (b) Name of husband or wife **Charles** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **Jan. 19, 1883**

8. AGE: Years **57** Months **6** Days **27** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Larocoe, Missouri**  
 10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_  
 12. Name **Neddie Hubbard**  
 13. Birthplace **Ohio**  
 14. Maiden name **Luteta Whisner**  
 15. Birthplace **Illinois**

16. (a) Informant's own signature **Charles Shaffer**  
 (b) Address **Joplin, Mo.**  
 17. (a) **Burial** (b) Date thereof **8-17-40**  
 (c) Place: burial or cremation **Forest Park**

18. (a) Signature of funeral director **Thornhill Hillman**  
 (b) Address **Joplin, Mo.**  
 19. (a) **86-17-40** (b) **Ed. J. James**  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper**  
 (c) City or town **Joplin**  
 (d) Street No. **510 E. 32<sup>nd</sup> St.**  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **15<sup>th</sup>**  
 year **1940** hour **11:30** minute \_\_\_\_\_ P. M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw her **dead** on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
 Due to **Heart Block**  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

Major findings: Of operations \_\_\_\_\_  
 Of autopsy **Investigation**

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? **270**  
 (Specify type of place) (e) Means of injury **Brown**  
 23. Signature **A. H. Winchester**  
 Address **Joplin, Mo.** Date signed **8-16-40**

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.

40-9-373

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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 F. M. Jones  
Licensed Embalmer No. 2319  
P. O. Address Japhin m

**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.**