

Registration District No. **411**

Primary Registration District No. **2002**

Registrar's No. _____

1. PLACE OF DEATH: **Jasper**
(a) County _____
(b) City or town **Joplin**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Freeman Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **26 Days**
(Specify whether years, months or days) **26 Days**

3. (a) PRINT FULL NAME **Jasper McCellan Timbrel**

3. (b) If veteran, name war: _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Cora Jane** 6. (c) Age of husband or wife if alive **70** years

7. Birth date of deceased **May 25, 1867**
(Month) (Day) (Year)

8. AGE: Years **73** Months **5** Days **23** If less than one day hr. _____ min. _____

9. Birthplace **Prairie Township, Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Banker---Retired**

11. Industry or business _____

12. Name **Jacob T. Timbrel**

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

14. Maiden name **Jemimah Spain**

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

16. (a) Informant **Mrs. Cora J. Timbrel**

(b) Address **Oskaloosa, Iowa**

17. (a) **Removal** (b) Date thereof **11-17-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oskaloosa, Iowa**

18. (a) Signature of funeral director **Thornhill-Dillon**

(b) Address **Joplin, Missouri**

19. (a) **11-17-40** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Iowa** (b) County _____
(c) City or town **Oskaloosa**
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **17**
year **1940** hour **11** minute **20** A.M.

21. I hereby certify that I attended the deceased from **Oct 22**, 19**40**, to **Nov 17**, 19**40**
that I last saw him alive on **Nov 17**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Diabetes mellitus**
Duration **?**
Due to **Arteriosclerosis, Vesicula Hypertrophied Prostate (Benign) 2 yrs.**
Due to **Prostatic reaction**

Other conditions (Include pregnancy within 3 months of death) **Acute urinary retention**
Major findings: **Prostate Hypertrophy**
Of operations _____
Of autopsy **not done.**

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? **372**
(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature **Paul W. Walker** (M. D. or other) **MD**
Address **Joplin, Mo.** Date signed **11-17-40**

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

RECEIVED DEC 10 1940

40-12-608

MDW 28 1944

621

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..... *David Nelson*

Licensed Embalmer No. *3898*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38883

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether years, months or days)

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

Jasper MacLellan Timberl

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 w
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years 73 Months 5 Days 23 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director.

(b) Address

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month 11 day 17 year _____ 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 Diabetes mellitus

Due to arterio sclerosis, uremia, hypertrophic prostate
Due to prostate resection 10-5-40

Other conditions acute urinary Retention
(Include pregnancy within 3 months of death)

Major findings: Prostatic Hypertrophy
Of operations _____

Of autopsy 137

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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Paul W. Walker (M.D. or other MD)
Address Joplin mo Date signed 1-30-41

SUPPLEMENTARY

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

S-38883