No. 2
-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

FILED FEB 14 1941

STANDARD CERTIFICATE OF DEATH

State File No. 2969

Registration District No. 411 Primary Registration District No. 2002 Registrar's No.

49
2
5

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

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: St Johns Hospital O (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Joplin 2 (If outside city or town limits, write "RURAL") 5

(d) Street No. 1426 Sergeant (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME J. Willard McCann

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 3 Divorced

6. (b) Name of husband or wife Divorced

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

7. Birth date of deceased Aug (Month) 4 (Day) 1884 (Year)

8. AGE: Years 56 Months 5 Days 2 If less than one day hr. min.

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

10. Usual occupation Sheet Metal Worker

11. Industry or business

FATHER
12. Name Albert McCann
13. Birthplace 4 England (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Frances Sanford
15. Birthplace 2 Canada (City, town, or county) (State or foreign country)

16. (a) Informant Mabel Wallace

(b) Address 23 15 Kentucky Joplin

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cem

18. (a) Signature of funeral director Webb City Und Co

(b) Address Webb City Mo

19. (a) 1-8-41 (Date received local registrar) (b) Ed B James (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from January 1 1941 to Jan 6 1941 that I last saw him alive on Jan 6 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Acute dilation of heart

Due to Empyema of Relaxing

Due to

Other conditions (Include pregnancy within 3 months of death) 110

Major findings: Of operations Empyema Relaxing

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)

(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? 377 (Specify type of place)

While at work? (e) Means of injury

23. Signature A. Mitchell Gregg (M. D. ~~or other~~) D

Address 607 Friscoe Bldg Date signed 1-8-41

(Licensed Embalmer's Statement on Reverse Side)

41-2-130

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No.

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

2. (a) PRINT FULL NAME
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex
5. Color or race
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of decedent (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day hr. min.
9. Birthplace

2. USUAL RESIDENCE OF DECEDENT:
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.
21. I hereby certify that I attended the deceased from 19, to 19; that I last saw it alive on 19 and that death occurred on the date and hour stated above.
Immediate cause of death Duration
Due to
Due to
Other conditions
Major findings: (Autopsy? Autopsy within 3 months of death)
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? (Specify type of place)

PHYSICIAN

Undersigned to which death should be reported officially.

10. Usual occupation
11. Industry or business
12. Birthplace (City, town, or county) (State or foreign country)
13. Birthplace (City, town, or county) (State or foreign country)
(a) Informant
(b) Address
14. (a) Signature of funeral director
(b) Address
15. (a) (Date received for registration) (Registrar's signature) (b)

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 myself working under my personal supervision, Registered Apprentice No.

Signed Clayton M. Johnston

Licensed Embalmer No. 3,922

P. O. Address Webb City, 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.

(Licensed Embalmer's Statement on Reverse Side)

FOR FUNERAL DIRECTOR'S USE ONLY

DEPARTMENT OF PUBLIC HEALTH—BLACK INK—PLEASE PRINT

1 X22659

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

ROWENA MOORE

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2969

Registration District No. 411 Primary Registration District No. 2002 Registrar's No.

SUPPLEMENTARY

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 (Jethro)
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 Jethro Willard McCann

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 Div
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 56 Months 5 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 1-8-41 (Date received local registrar) (b) Ed D. James (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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)
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature A. Mitchell Gregg (M. D. or other)
Address Joplin Mo Date signed

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

PLACE OF DEATH

USUAL RESIDENCE OF DECEASED:

MEDICAL CERTIFICATION

DATE OF DEATH:

PHYSICIAN

BURIAL PERMIT