

Registration District No. 1046

Primary Registration District No. 5810

Registrar's No.

1. PLACE OF DEATH:

(a) County Newton  
(b) City or town Newton  
(c) Name of hospital or institution:  
3800 Indiania St  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 10 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton  
(c) City or town Joplin (Rural) Shoal Creek  
(d) Street No. RFD # 3  
(e) If foreign born, how long in U. S. A.? 0 years.

8. (a) PRINT FULL NAME Flora Comer

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 Widow

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 1857 years

7. Birth date of deceased Dec 6  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
83 1 13 hr. min.

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

10. Usual occupation House Work

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Sheldon Shepard  
13. Birthplace Unknown  
14. Maiden name Unknown  
15. Birthplace Unknown

16. (a) Informant Albert Comer  
(b) Address R.R. 3 Box 116 Joplin Mo

17. (a) Removal (b) Date thereof 1-20-41  
(Date received from registrar) (Month) (Day) (Year)

(c) Place: burial or cremation Lowell, Kansas

18. (a) Signature of funeral director Daniel Funeral  
(b) Address Picher Okla

19. (a) 1-20-41 (b) [Signature]  
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 19  
year 1941 hour 10:00 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from January 4 1941 to January 7 1941  
that I last saw her alive on January 7 1941  
and that death occurred on the date and hour stated above.  
Immediate cause of death Mycocardial failure

Due to General arterio sclærosis:

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)  
(a) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) [Signature]  
Address Joplin Mo Date signed 1/20/41

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

RECEIVED

District Health Officer No. 6;

District File 141-241

Date Filed FEB 7 1941

99

STATE HEALTH RECORDS

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.....

*Robert Earl Fromm*

....., Registered Apprentice No.....

working under my personal supervision.

Signed *R. Earl Fromm*

Licensed Embalmer No. *875*

P. O. Address *Picher, Okla*

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. 3616

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 1046

Primary Registration District No. 5810

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Shoal Creek T.P.  
(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 Flora Corner

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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 Months Days If less than one day

83 1 13 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)

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 Jan day 19  
year 1941 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 Myocardial failure

Due to General Arteriosclerosis

Chronic Myocarditis

Other conditions Diabetes Mellitus  
(Include pregnancy within 3 months date)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy 92 W

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 W. J. Ireland (M. D. \_\_\_\_\_)

Address Japan Mo Date signed 1/24/41

SUPPLEMENTARY

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

PHYSICIAN  
Underline the cause to which death should be charged statistically.

