

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 35244

FILED NOV 14 1941

Registration District No. 411Primary Registration District No. 2002

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County Jasper, Mo.  
 (b) City or town Jasper, Mo.  
 (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 21 days  
 (Specify whether

In this community \_\_\_\_\_  
years, months or days)3. (a) PRINT FULL NAME Lottie Haley3. (b) If veteran, name war no. 3. (c) Social Security No. \_\_\_\_\_4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife S.H. Haley 6. (c) Age of husband 70 years7. Birth date of deceased Dec. 16 1876  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
64 8 3 hr. min.9. Birthplace McDonald Co. Mo.  
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

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

12. Name John Dabbs13. Birthplace Jenn. Tenn.  
(City, town, or county) (State or foreign country)14. Maiden name Katherine Johnson15. Birthplace McDonald Co. Mo.  
(City, town, or county) (State or foreign country)16. (a) Informant Mr. S.H. Haley(b) Address 345 East 22, Baxter Spg.17. (a) Reburied (b) Date thereof 9-21-41  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Anderson, Mo.18. (a) Signature of funeral director John H. Smith(b) Address 2008 S. Main, Jasper, Mo.19. (a) 10-25-41 (b) W. D. Jones  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Kansas (b) County 999  
 (c) City or town Baxter Spring, Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 345 East 22nd  
 (If rural, give location)  
 (e) Citizen of foreign country? no. (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19  
year 1941 hour 10 minute 15 AM

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw her alive on Sept. 19, 1941; and that death occurred on the date and hour stated above.Immediate cause of death Gastric Malignant Duration IDue to Generalized Arteriosclerosis

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) (e) Means of injury \_\_\_\_\_

23. Signature O. L. Martin (M. D. \_\_\_\_\_)Address Baxter Spg. Kansas signed 9-19-41

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

41-11-946

BEHAVIORAL RECORD

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 *John W. Hunt*  
Licensed Embalmer No. *820*  
P. O. Address *Dickinson Okla*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. **35244**

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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ 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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Lattie Haley**

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 **m**

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

7. Birth date of deceased **Dec 16** (Month) (Day) (Year)

8. AGE: Years **64** Months **8** Days \_\_\_\_\_ (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** year **1941** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

that I saw him/her alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

**Acute Malignancy**  
Due to **Generalized Atherosclerosis**

Due to **Carlinoma of pylorus**

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

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

Of autopsy **H&E**

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 **W.D. M.D.** (M. D. or other) \_\_\_\_\_  
Address **Carter Springs** Date signed **11/20/41**

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

SUPPLEMENTARY

S-35244