

1. PLACE OF DEATH:

(b) County Jasper
(b) City or town Joplin
(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 5 years
In this community 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Joplin
(d) Street No. 1301 Delaware
(e) Citizen of foreign country?
If yes, name country

3. (a) PRINT FULL NAME Emily Angie Tinsley

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife A. Tinsley Age of husband or wife if alive years

7. Birth date of deceased Sept 8 1853
(Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 9
If less than one day .hr. .min.

9. Birthplace Bedford, Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name William H. Gardner
13. Birthplace Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs H.B. Hyde
(b) Address 1301 Delaware Ave, Joplin

17. (a) Burial (b) Date thereof 4 19 42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Orla, Mo.

18. (a) Signature of funeral director Thornhill-Dillon
(b) Address Joplin, Mo.

19. (a) 4-17-42 (b) Arthur Rudholter
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17th
year 1942 hour 10 minute A.M.

21. I hereby certify that I attended the deceased from March 10-42
to April 16 1942
that I last saw her alive on April 15 1942
and that death occurred on the date and hour stated above.

Immediate cause of death
Due to Acute nephritis
Gen debility

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?

While at work? (Specify type of place)
(e) Means of injury
23. Signature W.H. Thornhill-Dillon (D. or other)
Address 4-17-42 Date signed

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

MOTHER FATHER

12 84

424-409

Handwritten notes in the top left corner, including "424-409" and other illegible scribbles.

Handwritten notes in the middle left area, including "did not see" and "fact should be so stated above".

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 Carl O. Thomsen

Licensed Embalmer No. 3590

P. O. Address Deplin, 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. 14657

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

1. PLACE OF DEATH:

(a) County Gasper

(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 5 yrs
(Specify whether years, months or days)

In this community 5 yrs

3. (a) PRINT FULL NAME Emily A. Dinsley

3. (b) If veteran 9 name war 9

3. (c) Social Security No. _____

4. Sex ♀ 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 Sept - 10 - 1884
(Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days _____
If less than one day

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

10. Usual occupation _____

11. Industry of 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 MO (b) County Gasper

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

(d) Street No. 1301 Delaware
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day _____
Year 1942 Hour _____ Minute _____ a.m.

21. I hereby certify that I attended the deceased from _____ to _____
that I last saw him _____ days on _____, 19____
and that death occurred on the date and hour stated above, 19____

Immediate cause of death acute nephritis
and renal debility

Due to Chronic nephritis

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)

(c) Means of injury _____

23. Signature W. B. Brooks Date signed 6/2/42
Address Joplin mo

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

SUPPLEMENTARY

MOTHER FATHER

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

