

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1167

State File No. _____

Registrar's No. **16**

FILED JAN 29 1943
Registration District No. _____

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days** (Specify whether
In this community **3 days** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **14**
(c) City or town **Louisburg** (If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **2**

3. (a) PRINT FULL NAME **Miss Iola Josephine Joslin**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

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

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

7. Birth date of deceased. **September 12 1873**
(Month) (Day) (Year)

8. AGE: Years **69** Months **3** Days **20** If less than one day hr. min.

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

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER { 12. Name **George W. Joslin** Birthplace **Unknown** 9

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

14. Maiden name **Martha M. Winebrenner**

15. Birthplace **Unknown** 9 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Marjorie R. Eckerson**

(b) Address **4549 Main St.**

17. (a) **Cremation** (Burial, cremation, or removal) (b) Date thereof **1-5-1943** (Month) (Day) (Year)

(c) Place of burial or cremation **Elmwood Cemetery**

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **Kansas City, Mo.**

19. (a) **1-4-43** (Date received local registrar) (b) **m. m. Crowe** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **2nd** year **1943** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **Dec. 31 1942** to **Jan. 2 1943**; that I last saw him alive on **Jan. 2 1943**; and that death occurred on the date and hour stated above.

Immediate cause of death: **1-Chronic vascular nephritis - years**
2-Arteriosclerosis

Due to **3-Cardiac hypertrophy**

Due to **131a**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

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? _____

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

23. Signature **Mont Hinkle** (M. D. or other) _____
Address **Trinity Hospital** Date signed _____

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

Handwritten notes:
11:30-5:00
11608
11608
11608
11608
11608

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 Clarence W. Chiles
Licensed Embalmer No. 3473
P. O. Address 76 E 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.