DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 29 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10571

Registration District No. 156 — Primary Registration District No. 2001 — Registrar's No. 156

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: 828½ Main Street 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community 55 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49 9

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

(d) Street No. 828½ Main Street (If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Tom Price

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White 0

6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife

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

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years 85 Months Approx Days mately If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Unkown
13. Birthplace (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unkown
15. Birthplace (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs. Lula Fife

(b) Address 828½ Main Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-43 (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director Parker-Hunsaker

(b) Address 1502 Joplin Street

19. (a) 3-15-43 (Date received local registrar) (b) Gertrude Sudhoeller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mch day 13 year 1943 hour 2:00 minute A M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on Did not see him alive 19 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Tract Failure	
Due to Senility	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 93	
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 Coronary

23. Signature R. H. Hefsler (M. D. or other)

Address Carthage Mo Date signed Mch 13 '43

1204 (Licensed Embalmer's Statement on Reverse Side)

43-3-239

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 F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
DM—8-21-41
I X29288

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(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 years, months or days)

In this community

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: Tom Price

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: Single

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: 85 Months: — Days: If less than one day hr. 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) (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May Day: 13 year: 1943 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	Duration
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.

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(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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-10571