

FILED MAY 6 1943

Registration District No. 149

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 10 hours
In this community 120 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 19
(c) City or town Joplin (If outside city or town limits, write "RURAL") 2
(d) Street No. 48th & Indiana Ave. (If rural, give location) 5
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Elizabeth Maier

3. (b) If veteran, name war No 3. (c) Social Security No. 490-20-1497

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 6 1924
(Month) (Day) (Year)

8. AGE: Years 18 Months 7 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace: Joplin Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Cashier

11. Industry or business Belden Electric Co.

MOTHER FATHER { 12. Name George K. Maier
13. Birthplace Fort Wayne Ind.
(City, town, or county) (State or foreign country)
14. Maiden name Nellie Marie Hicks
15. Birthplace Joplin Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant George K. Maier
(b) Address Joplin, Mo.

17. (a) Removal (b) Date thereof 4-27-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Joplin, Mo.

18. (a) Signature of funeral director Freeman Mortuary
(b) Address Kansas City, Mo.

19. (a) 4/27/43 (b) W. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw h Respectively Coroner _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Premature labor complicated by fatal hemorrhage.
Due to cause undetermined pending further investigation
Other conditions pending further investigation
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy See above

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) Means of injury _____
Signature Dr. E. Washner (M. D. or other) D.M.M.
Address 23rd Meley Date signed 4/27/43

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

62-1-3-100-10

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 H. Chiles
Licensed Embalmer No. 3473
P. O. Address 16 C. 100

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

not given

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **1985**

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(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.....
In this community..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mary Elizabeth Maier**

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

5. Color or race..... 6. (a) Single, widowed, married, divorced.....

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
18 yrs. 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town **Joplin**
(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 **April** day **27th** year **1948** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death **Premature Labor complicated by fatal hemorrhage**

Due to..... **14113**

Due to.....

Other conditions..... (Include pregnancy within 3 months of death) **14182**

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..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-13291