

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14566

State File No. _____

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. 242

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:
710 Picher
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 35 Yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State M (b) County Jasper

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

(d) Street No. 710 Picher Street
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME FRANK ELMER MARLIN

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 Married

6. (b) Name of husband or wife Cora 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased Dec 11 1878
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 15 If less than one day hr. _____ min.

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

10. Usual occupation Niti watch man

11. Industry or business Joplin Special Road Dist.

12. Name Madison Marlin

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

14. Maiden name Calla Owens

15. Birthplace Dallas, Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Cora Marlin

(b) Address 710 Picher

17. (a) Burial (b) Date thereof 4 29 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ozark Memorial

18. (a) Signature of funeral director Parker Hunsaker

(b) Address Joplin, Mo.

19. (a) 4-27-1943 (b) Gettysburg
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26th
year 1943 hour 10:30 minute A M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to Hypertension

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration several
months

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 Walter Hunsaker (M. D. or other) MA

Date signed 4/28/43

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

MOTHER FATHER

43-4-423

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 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. 14566
Registrar's No. 242

Registration District No. 156

Primary Registration District No. 2001

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 35 yr.
years, months or days

3. (a) PRINT FULL NAME

Frank E. Marlin

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 m

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

7. Birth date of deceased Dec. 11 - 1885
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 15 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or 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) 5-28-43 (b) Gertrude Sudhalla
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
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)
(b) 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 _____ (M. D. or other)
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

SUPPLEMENTARY

S-14564

on 1/1/00