

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

N
-5-42
17-39
X32877

FILED MAY 27 1943

Registration District No. 206

Primary Registration District No. 2001

Registrar's No. 259

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:
St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Always years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Joplin
(If outside city or town limits, write "RURAL")
(d) Street No. 2418 Moffet
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Grace Heatherington

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Roscoe 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Feb. 27 1885
(Month) (Day) (Year)

8. AGE: Years 58 Months 2 Days 8 If less than one day hr. _____ min. _____

9. Birthplace Joplin Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name James T. Bodine
13. Birthplace Joplin Mo. 0
(City, town, or county) (State or foreign country)
14. Maiden name Steph M. Conroy
15. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant J. C. Bodine

(b) Address 2419 Bird

17. (a) Burial (b) Date thereof 5-7-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview

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

(b) Address Joplin, Missouri

19. (a) 5-6-43 (b) Gertrude Sudhalter
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5th
year 1943 hour 8 a.m. minute _____ M. _____

21. I hereby certify that I attended the deceased from 4-26, 1943, to 5-5, 1943;
that I last saw her alive on 5-4, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Acute Cardiac Nihilis 1/2 hr
Partial Cerebral Thrombosis 1/2 hr
(Post-operative)
Acute Peritonitis 3 hrs
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 [Signature] (M. D. or other) MD
Address _____ Date signed 5/6/43

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

43-5-435-

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..... *Jensen 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. _____

Registration District No. 175

Primary Registration District No. 5647

Registrar's No. 48

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

1. PLACE OF DEATH

(a) County Taylor
(b) City or town Joplin
(c) Name of hospital or institution: St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

3. (a) PRINT FULL NAME

Grace Neatherington

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

4. Sex F 5. Color or race W 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: Feb 27 (Month) (Day) (Year)

8. AGE: Years 58 Months 2 Days _____ If less than one day _____ min.

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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 _____ (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 MARCH Day _____
year 1943 hour _____ minute _____ M.

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

Due to probably cerebral thrombosis

Due to (post operative)

Other conditions acute peritonitis
(include pregnancy within 3 months of death)

Major findings probable rent of spleen 2 1/4"
Of operations capsule 12/11

Of autopsy exact cause unknown

Duration

1/2 hr.

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)
(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 [Signature] (M. D. or other) _____
Address _____ Date signed _____

ST. JOHN'S HOSPITAL

S-18714