

Registration District No. 156

Primary Registration District No. 2001

State File No. \_\_\_\_\_

Registrar's No. 649

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. John's Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)  
 In this community 50 years

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. 1935 Manitow  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ella G. Smith  
 3. (b) If veteran, name war none  
 3. (c) Social Security No. none

4. Sex F  
 5. Color or race W  
 6. (a) Single, widowed, married, divorced, widowed  
 6. (b) Name of husband or wife Cyrus T. Smith  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased August 4, 1864  
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 20  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 { 12. Name unknown  
 { 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 { 14. Maiden name unknown  
 { 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant O. B. Smith  
 (b) Address Sapulpa, Oklahoma

17. (a) burial (b) Date thereof 11/26/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Masonic cemetery, Jasper

18. (a) Signature of funeral director PARKER HUNSAKER  
 (b) Address 1502 Joplin, Joplin, Mo.

19. (a) 11-26-43 (b) Justus Sudbatter  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 24  
 year 1943 hour 11 minute 17 - A. M.

21. I hereby certify that I attended the deceased from Nov 23 to Nov 24 1943  
 that I last saw her alive on Nov 24 1943  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism

Due to fracture of hip, accidental fall in her  
room 30 hrs

Other conditions \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) 12021  
 (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 \_\_\_\_\_

23. Signature St. Germain (M. D. or other)  
 Address Joplin Mo Date signed 11-26-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

43-11-949

**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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *Dec*

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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. John's Hosp.*  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution *2 da.* (Specify whether  
In this community *50 yr.* years, months or days)

3. (a) PRINT FULL NAME *Ella G. Smith*  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased *Aug. 4 - 1902*  
(Month) (Day) (Year)

8. AGE: Years *79* Months *3* Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (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 \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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 *Nov.* Day *24* Year *1948* Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_

*pneumonia embolus fracture Rt. hip*

Due to *accident - fall in her home.*

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) *186 a*

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) *accident*

(b) Date of occurrence *Nov 23 1948*

(c) Where did injury occur? *Joplin Jasper MO* (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *her home*

While at work? *Yes* (Specify type of place) (c) Means of injury *fracture hip*

23. Signature *J. H. Cerless* (M. D. or other) Address *Joplin Mo* Date signed *11/16-48*

SUPPLEMENTARY

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

38476