

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

FILED JAN 14 1944

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: Freeman 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 Garrett Walter Kraft

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

4. Sex Male 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 December 16 1882  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
61 7 ..hr. min.

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

10. Usual occupation Elevator Operator

11. Industry or business.....

12. Name J. H. Kraft

13. Birthplace St Louis Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Schwartz

15. Birthplace St Madison Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs A Ashley

(b) Address Neosho Missouri

17. (a) Removal (b) Date thereof 12/31/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Neosho Mo

18. (a) Signature of funeral director W. J. ...

(b) Address Neosho Mo

19. (a) 12-27-43 (b) Quentin ...  
(Date received local registrar) (Registrar's signature)

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..... (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23  
year 1943 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dec. 17 1943 to Dec. 23 1943  
that I last saw him alive on Dec. 23 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: myocarditis (chronic)  
hypertosis

Due to.....  
Due to.....  
Other conditions (Include pregnancy within 3 months of death).....

Duration  
5  
3

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?  
No  
While at work?..... (Specify type of place)  
(e) Means of injury.....

23. Signature Walter L. ... (M. D. or other)  
Address Joplin Mo Date signed 12/27/43

43-12-1083

FEB 16 1944

**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 *J. B. Bishop*  
Licensed Embalmer No. *2689*  
P. O. Address *Neesho*

**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. Jan.  
Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District 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: Freeman Home  
(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)

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 Garrett W. Kraft

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 S

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

7. Birth date of deceased Dec. 16 (Month) (Day) (Year)

8. AGE: Years 61 Months \_\_\_\_\_ Days \_\_\_\_\_ (less than one day) min. \_\_\_\_\_

9. Birthplace Joplin (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) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 13 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 myocarditis (chronic)  
nephrosis (acute)

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

Other conditions. (Include pregnancy within 3 months of death) \_\_\_\_\_

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

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

Duration \_\_\_\_\_  
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 Lois L. Kelly (M. D. or other) \_\_\_\_\_

Address Joplin Date signed 1/27/44

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SUPPLEMENTAL

FEB 16 1974