

FILED FEB 28 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7391

Registration District No. 136

Primary Registration District No. 2001

Registrar's No. 87

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:
1818 Grand Avenue /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether
 In this community..... 45 years
years, months or days)

3. (a) PRINT FULL NAME Mary E. Caskey

3. (b) If veteran, name war none
 3. (c) Social Security No. none

4. Sex Female / 5. Color or race White
 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Elmer P. Caskey
 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased February 15, 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>11</u>	<u>23</u>	hr. min.

9. Birthplace Mattoon Illinois /
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business

12. Name Silas J. Fentress

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

14. Maiden name Harriett E. Gilmore

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

16. (a) Informant C. W. Caskey(b) Address 2010 Kentucky, Joplin, Mo.

17. (a) Permal (b) Date thereof 2/14/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parsons, Kansas(a) Signature of funeral director PARKER-HUNSAKER(b) Address 1502 Joplin, Joplin, Mo.

19. (a) 2-9-44 (b) Justin Reichelt
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49
 (c) City or town Joplin 2
(If outside city or town limits, write "RURAL") 5
 (d) Street No. 1818 Grand Avenue
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 8
 year 1944 hour 11:00 minute 10 M.

21. I hereby certify that I attended the deceased from
July 27, 1942 to Feb 8, 1944
 that I last saw her alive on Feb 8, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death

Myocardial failure
Arterio sclerosis
and acute nephritis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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 W. Shoveland (M. D. or other)Address Joplin Mo Date signed 2/9/44

40-2-149

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. 2719

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. _____

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. 87

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Jasper
(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 _____ years, months or days

3. (a) PRINT FULL NAME

Mary E. Canbey

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 W

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

7. Birth date of deceased Feb. 15 (Month) (Day) (Year)

8. AGE: Years 74 Months 11 Days _____ If less than one day _____ 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) _____ (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 Feb year 1984 hour _____ minute _____ M.

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

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction Duration _____

Due to arteriosclerosis and acute nephritis following

Due to attack of influenza

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

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 330
Of operations _____
Of autopsy _____ PHYSICIAN _____

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 Jasper (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTAL INFORMATION REQUESTED

7391