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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 28 1944

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. 94

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Joplin, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2125 Maryland, 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 yr. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Joplin, Mo. 25
(If outside city or town limits, write "RURAL")

(d) Street No. 2125 Maryland, (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WILLIAM THOMAS McCoy

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 1

6. (b) Name of husband or wife Samantha McCoy

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased July 1 1860
(Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days 13 If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business

12. Name William McCoy

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

14. Maiden name Missouri Applegate

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

16. (a) Informant Samantha McCoy

(b) Address 2125 Maryland Joplin, Mo.

17. (a) Burial, cremation, or removal: Burial (b) Date thereof: 2-16-1944 (Month) (Day) (Year)

(c) Place: burial or cremation: Prospect Cem Joplin, Mo.

18. (a) Signature of funeral director: Webb City and Co.

(b) Address: Webb City, Mo.

19. (a) Date received local registrar: 2-15-44 (b) Registrar's signature: Gustaf Rudolph

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 12th year 1944 hour 4:30 minute 30 M.

21. I hereby certify that I attended the deceased from December 1943 to February 12, 1944 that I last saw him alive on January 15, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Asphyxia

Due to: Cardiac Failure

Due to: Senility

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

Major findings: Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) (9) Means of injury

23. Signature: Dr. Mississippian (M. D. or other) D.O. Address: 411-12 Minor Blvd. Date signed: 2/15/44

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

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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 myself

....., Registered Apprentice No.

working under my personal supervision.

Signed: Blayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Webb City, 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.

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. 94

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(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 Wm Thomas McCoy

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 _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 83 Months 7 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (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 Feb year 1944 hour _____ minute _____ M. 2

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

that I last saw him _____ alive on _____ 19____ and that death occurred on the date and hour stated above.
Immediate cause of death Asphyxia Duration _____

Due to cardiac failure

Due to Chronic Myocarditis

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

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 938
Of operations _____
Of autopsy _____

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? No (Specify type of place) _____ (e) Means of injury _____

23. Signature Dr. Mildred E. Ferguson & Co. (Date received local registrar) (Registrar's signature)
Address 4112 Minors Bank Date signed _____

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

SUPPLEMENTARY INFORMATION REQUESTED

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