U. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 16 1945

Registration District No. 256

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 2503

Primary Registration District No. 2001

Registrar's No. 636

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

**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 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 22 Days (Specify whether years, months or days)

In this community: 25 Yrs

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Mo (b) County: Jasper

(c) City or town: Joplin (If outside city or town limits, write "RURAL")

(d) Street No.: 614 ½ W 6th St (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: Edith Ann Brown

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: Widowed

6. (b) Name of husband or wife:

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

7. Birth date of deceased: May (Month) 28 (Day) 1869 (Year)

8. AGE: Years 76 Months 7 Days 5 If less than one day hr. min.

9. Birthplace: Texas Co Mo; (City, town, or county) (State or foreign country)

10. Usual occupation:

11. Industry or business: Housewife

MOTHER FATHER

12. Name: Joseph Rust

13. Birthplace: Unknwon (City, town, or county) (State or foreign country)

14. Maiden name: Unkwnon

15. Birthplace: Unknwon (City, town, or county) (State or foreign country)

16. (a) Informant: Don F Brown

(b) Address: Webb City, Mo;

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 4 45 (Month) (Day) (Year)

(c) Place: burial or cremation: Ozark Mem

18. (a) Signature of funeral director: Parker Hungaker

(b) Address: Joplin, Mo;

19. (a) 1-5-45 (Date received local registrar) (b) Gertrude Shelton (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan day 2 year 1945 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from Dec 11 1944 to Jan 2 1945 that I last saw her alive on Jan 2 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Embolus

Duration: Instant

Due to: 1 hr

Due to: 3 yr

Other conditions (Include pregnancy within 3 months of death): Extra Capsular Fracture Left

Major findings: Of operations: Femur — Smith Peterson Pin

Of autopsy: Refused 12/29/44

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): Dec 11-1944 12:00

(b) Date of occurrence: 12/11/44

(c) Where did injury occur? Fell on Sidewalk (City or town) Jpn (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: [illegible] (M. D. or other)

Address: [illegible] Date signed: 1/5/45

(Licensed Embalmer's Statement on Reverse Side)

45-1-2

JAN 17 1945

## 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.**