

S. No. 2
M-3-43
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2517
Registrar's No. 28

FILED JAN 24 1945
Registration District No. 156

Primary Registration District No. 2001

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

AK: Miles
recovered
1-17-45

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 1
(Specify whether 1)
In this community 1
years, months or days

3. (a) PRINT FULL NAME Lena Belle Compton
(b) If veteran, name war _____ (c) Social Security No. _____

4. Female 5. Color White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Orvil O. Compton 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased April 6, 1890
(Month) (Day) (Year)

8. AGE: Years 54 Months 9 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name A. B. Atwood

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

14. Maiden name Rose Smith

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

16. (a) Informant Orvil O. Compton

(b) Address Joplin, Mo.

17. (a) Buried (b) Date thereof Jan 17-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director W. H. City, W. H. Co.

(b) Address W. H. City, 275 E. 1st St.

19. (a) 1-17-45 (b) Arthur J. Smith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper
(c) City or town Joplin, Mo.
(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 Jan day 13
year 1945 hour 7 minute 25 A.M.

21. I hereby certify that I attended the deceased from Dec. 27, 1944 to Jan. 13, 1945
that I last saw her alive on Jan. 13, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Toxemia Duration 3-4 hrs

Due to Infectd, gangrenous left foot 4-5 hrs

Due to Diabetes-mellitus 5 yrs

Other conditions Arterio-sclerosis ?
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations none

Of autopsy none 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 A. J. Telange (M. D. or other) MD

Address 107 Main, Joplin, Mo. Date signed 1-17-45

1204

(Licensed Embalmer's Statement on Reverse Side)

45-1-27

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 Clayton 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.