

V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 13 1945
Registration District No. 155

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 3127

State File No. 2613
Registrar's No. 14

19
6
26
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jaasper
(b) City or town Webb City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jane Chinn Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
In this community 5 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Esther LeRoy Rickey
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 January 14, 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 5 _____ hr. _____ min.

9. Birthplace Webb City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business _____

12. Name Esther Rickey
13. Birthplace Salisaw Oklahoma
(City, town, or county) (State or foreign country)
14. Maiden name Betty Fleming
15. Birthplace Joplin Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Esther Rickey
(b) Address R.F.D. # 1, Webb City, Mo.

17. (a) burial (b) Date thereof 1/20/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Forest Park Cemetery

18. (a) Signature of funeral director PARKER-HUNSAKER
(b) Address 1504 Joplin, Joplin, Missouri
19. (a) Jan. 20, 1945 Mrs. Lillie Dagle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jaasper
(c) City or town Webb City
(If outside city or town limits, write "RURAL")
(d) Street No. Jane Chinn Hospital
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 19
year 1945 hour 5 minute 35 A.M.
21. I hereby certify that I attended the deceased from 1-14-45
_____, 19____, to 1-19 _____, 19____
that I last saw him alive on 1-18 _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Idiopathic meningitis Duration 4 days
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
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? _____ (Specify type of place)
(e) Means of injury _____
23. Signature R. M. Mahoney (M. D. or other) Do
Address Joplin, Missouri Date signed 1-19-45

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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.....

....., 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.