

SEP 6 1945 248

Registration District No.

Primary Registration District No. 5843

Registrar's No.

1. PLACE OF DEATH:

(a) County Newton  
(b) City or town Joplin  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Rural, Shoal Creek Twn. /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 25 years. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73  
(c) City or town Rural Route 2, Galena Kansas  
(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 No

3. (a) PRINT FULL NAME

Jennie Louisa Enlow

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex fem. / 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Charles W. Enlow 6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased Feb. 4, 1873.  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>6</u>	<u>15</u>	hr. _____ min.

9. Birthplace Henry Co. Mo; (City, town, or county) (State or foreign country) 0

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

12. Name David Jackson  
13. Birthplace Indiana (City, town, or county) (State or foreign country) 1  
14. Maiden name Lydia Cates  
15. Birthplace Henry Co Mo. (City, town, or county) (State or foreign country) 0

16. (a) Informant Chas W. Enlow  
(b) Address Galena Kansas, R-2  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-45 (Month) (Day) (Year)  
(c) Place: burial or cremation Fairview Cem.

18. (a) Signature of funeral director Hurlbut Und. Co.  
(b) Address Joplin Mo.  
19. (a) Aug. 25-45 (b) Nettie Norris (Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. 19 day 1945  
year \_\_\_\_\_ hour 11-50 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Aug 18 1945 to Aug 19 1945  
that I last saw him alive on Aug 19 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Infarctus Duration 48 hrs  
Due to Wound of foot accidental 3-15-46

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 73  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence 8-13-45  
(c) Where did injury occur? Newton MO (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Farmer (Specify type of place)

While at work? Yes (Specify type of place) (a) Means of injury injury to foot  
23. Signature H. W. [unclear] (M. D. or other)  
Address Galena MO Date signed 8-20-45

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

MOTHER FATHER

JUN 16 1949

RECEIVED  
SEP 4 1945  
District Health Officer No. *New York*  
District File Number *948-156*  
Date Filed *9-5-45*

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 *Samuel K. Zurek*  
Licensed Embalmer No. *959*  
P. O. Address *Spring Hill*

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. (248)

Primary Registration District No. (5843)

1. PLACE OF DEATH;

(a) County Newton  
(b) City or town Diamond R.R. #  
(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 Jessie L. Eubank  
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 m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb - 4 (Month) (Day) (Year)

8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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) \_\_\_\_\_ (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 \_\_\_\_\_

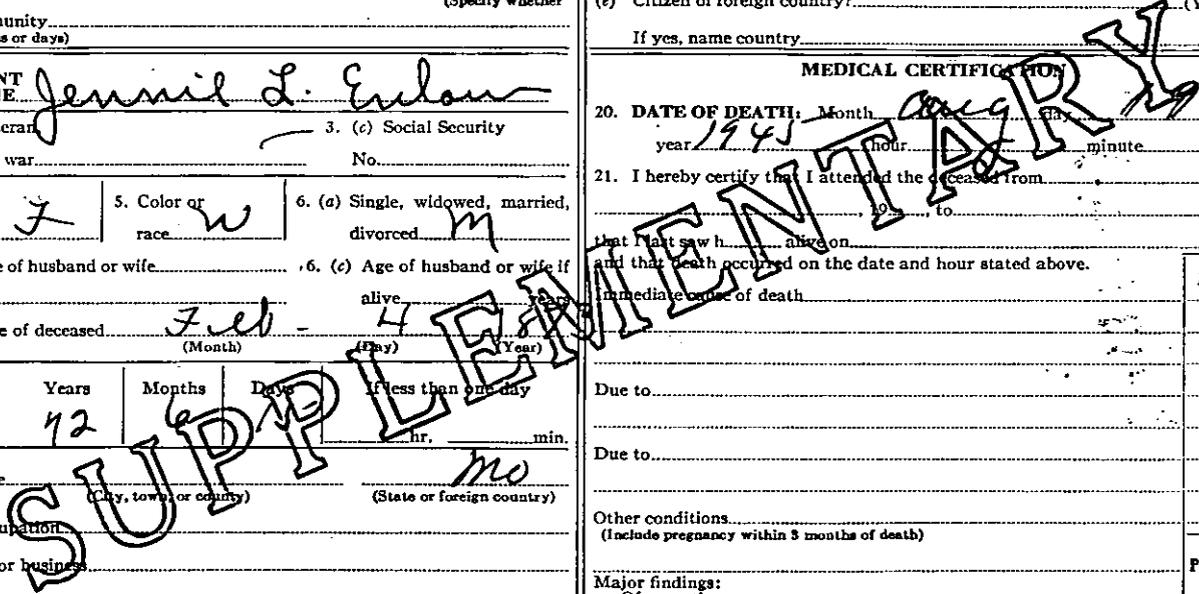
MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day \_\_\_\_\_  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Duration \_\_\_\_\_  
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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_



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

S-28058