

FILED OCT. 9 1945

Registration District No. _____

Primary Registration District No. **2301**

Registrar's No. _____

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. John's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **50 days**
(Specify whether years, months or days)
In this community **70 years**

3. (a) PRINT FULL NAME **Dora E. Ade**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Widowed**
7. Birth date of deceased **June 14, 1855**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
90 2 29 hr. min.

9. Birthplace **Bohemia**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Joseph Schieberl**
13. Birthplace **not known** **Bohemia**
(City, town, or county) (State or foreign country)
14. Maiden name **not known**
15. Birthplace **not known**
(City, town, or county) (State or foreign country)

16. (a) Informant **Frank Ade**

(b) Address **2016 Pennsylvania, Joplin, Mo.**

17. (a) **burial** (b) Date thereof **9/17/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Hope Cemetery**

18. (a) Signature of funeral director **PARKER-HUNSAKER**

(b) Address **1502 Joplin, Joplin, Missouri**

19. (a) **9-15-45** (b) **Ed. D. Smith**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper** **44**
(c) City or town **Joplin** **2**
(If outside city or town limits, write "RURAL")
(d) Street No. **2016 Pennsylvania** **5**
(If rural, give location)
(e) Citizen of foreign country? **no** **0**
(Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **13**
year **1945** hour **11** minute **30P** M.

21. I hereby certify that I attended the deceased from **July 25-1** 19**45** to **Sept 13-1** 19**45**
that I last saw him alive on **Sept 13-1** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial degeneration** **5.**
Due to **coronary atherosclerosis**

Due to **Sustained fracture of hip July 20-1 1945**
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
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) **122**
(b) Date of occurrence **9/13/45**
(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) (d) Means of injury _____

23. Signature **Ruth I. Huff** (M. D. officer)
Address **Joplin Mo** Date signed **9/14/45**

45-9-755

OCT 19 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Oct
Registrar's No. _____

Registration District No. 156 Primary Registration District No. 2001

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:
(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 Dora E. Ade
3. (b) If veteran, _____ 3. (c) Social Security
name war _____ No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 14 (Month) (Day) (Year)

8. AGE: Years 90 Months 2 Days 2 If less than one day hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country) Behrens

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(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 July day 25 year 1945 hour _____ minute _____ M. _____
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

Due to _____
Due to _____
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) Accident
(b) Date of occurrence July 25, 1945
(c) Where did injury occur? In home - missed
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In home - Joplin Mo
While at work? No (Specify type of place) (e) Means of injury missed
23. Signature Robt. L. NEFF (M. D. or other) MD
Address Joplin Mo Date signed 7/31/45

SUPPLEMENTARY

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

30707