

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

**FILED FEB 21 1946**  
Registration District No. **256**

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:  
Joplin General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 28 days  
In this community 9 Years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph Hathaway

3. (b) If veteran, name war World War I  
3. (c) Social Security No. \_\_\_\_\_

4. Sex M. 5. Color or race W.  
6. (a) Single, widowed, married, divorced unk.

6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive 1887 years (Day) (Year)

7. Birth date of deceased January (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>00</u>	<u>21</u>	_____ hr. _____ min.

9. Birthplace Bentonville, Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Baker

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

MOTHER FATHER

12. Name Carl Hathaway  
13. Birthplace Des Moines, Iowa  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Howard  
15. Birthplace Bentonville, Ark.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Zack Cooper  
(b) Address 434 N. Connor, Joplin, Mo.

17. (a) Removal (b) Date thereof 1-30-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rogers, Ark

18. (a) Signature of funeral director Parker-Hunsaker  
(b) Address 1502 Joplin, Joplin, Mo.

19. (a) 2-2-46 (b) Ed Jones  
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper  
(c) City or town Joplin  
(If outside city or town limits, write "RURAL")  
(d) Street No. 436 North Connor  
(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 28  
year 1946 hour 9 minute 20 P M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Infection  
Duration \_\_\_\_\_

Due to 3rd degree burns

Due to over the face - arms

Other conditions with chest  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 1/15 Coroner's investigation

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 Jan 1 - 1946

(c) Where did injury occur? Joplin Joplin Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home - Home Burned  
While at work? No (Specify type of place) (e) Means of injury Burns

23. Signature A. W. Bennett (M. D. or other) Dr  
Address 2114 Joplin Date signed 1/27/46

46-1-1021

MAR 4 1946

MAR 29 1946

**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.**

o. 2B -  
-3-45  
I X43880

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Jasper  
(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)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME

Joseph Hathaway

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

4. Sex m 5. Color or race w.

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 59 Months 0 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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) Ed W. Jones  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 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 \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

6113