

2
13
5-17-39
I, X36671

FILED MAY 22 1946
Registration District No. **138**

Primary Registration District No. **2001**

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:
1809 Grand Ave., /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
years, months or days) **3 years**

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

3. (a) PRINT FULL NAME **Almira Red**

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 **Wid**

6. (b) Name of husband or wife **unk**

6. (c) Age of husband or wife if alive **unk** years

7. Birth date of deceased **February 15, 1856**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
90	2	14	hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER, FATHER

12. Name **Samuel Sowers**

13. Birthplace **Pennsylvania**
(City, town, or county) (State or foreign country)

14. Maiden name **Marie Faulkner**

15. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. C. O. Mook**

(b) Address **Seneca, Missouri**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **5-1-46**
(Month) (Day) (Year)

(c) Place: burial or cremation **Seneca, Missouri**

18. (a) Signature of funeral director **Parker-Hunsaker**

(b) Address **1502 Joplin, Joplin, Mo.**

19. (a) **5-10-46** (Date received local registrar) (b) *[Signature]* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Newton** **13**

(c) City or town **Seneca** **4**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) **0**

(e) Citizen of foreign country? **No** (Yes or No) **1**

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **29**
year **1946** hour **11** minute **A** M.

21. I hereby certify that I attended the deceased from **1 March**
19 **46** to **20 April** 19 **46**
that I last saw h. **unk** alive on **20 April** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerosis Heart Disease** **10 yrs**

Due to _____

Due to _____

Other conditions **Senility**
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy **97**

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 **[Signature]** (M. D. or other) **5-24-46**

Address **628 1/2 Main St** Date signed **5-24-46**

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

46-4-355

95.01
5-1-1962
10

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 Steve Parker
Licensed Embalmer No. 2348
P. O. Address W. H. M.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JurnalRegistration District No. 156Primary Registration District No. 2001

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:

(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 NAMEAlmia Red

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 unknown6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased Feb 15 (Month) (Day) (Year)8. AGE: Years 90 Months _____ Days _____ If less than one day _____ hr. _____ min.9. Birthplace _____ (City, town, or county) _____ (State or foreign country) Va

10. Usual occupation _____

11. Industry or business _____

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) E. O. James (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 April year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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 _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

S-17019