

No. 2  
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State File No. \_\_\_\_\_

FILED AUG 20 1946

Registration District No. 156

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:  
709 Byers /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 4 years ! (Specify whether \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Emmitt A. Crowell

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

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced S /

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

7. Birth date of deceased December 19 1903  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>42</u>	<u>6</u>	<u>24</u>	hr. _____ min.

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

10. Usual occupation Martins Machinery

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

MOTHER FATHER { 12. Name Haywood Crowell 9

{ 13. Birthplace no data 9  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Sarah Sullivan

{ 15. Birthplace Marionville Missouri 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Friend Mrs. Huddleston

(b) Address Joplin, Mo.

17. (a) Burial (b) Date thereof 7/16/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Heige-Lewis

(b) Address Webb City, Mo.

19. (a) 7-30-46 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Joplin 2  
(If outside city or town limits, write "RURAL")

(d) Street No. 709 Byers 5  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13  
year 1946 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from 4/16/46  
\_\_\_\_\_ 19 \_\_\_\_\_ to 7/13/46 19 \_\_\_\_\_  
that I last saw h im alive on 7/13/46 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary hemorrhage Dropsy

Due to pulmonary tuberculosis with cavitation.

Due to \_\_\_\_\_

Other conditions coronary disease  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_ 13/46

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) (c) Means of injury \_\_\_\_\_

23. Signature [Signature] (Date or other) \_\_\_\_\_

Address [Address] Date signed 7/24/46

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

46-7-655

*J. Johnson*

X:

**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..... *E. H. Helge* .....

Licensed Embalmer No. *2859*

P. O. Address *North City 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.**

Sept

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 (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

Emmitt A. Crowell

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month July 13  
 year 1941 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 \_\_\_\_\_

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

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

7. Birth date of deceased: Dec 19  
(Month) (Day) (Year)

8. AGE: Years 42 Months 6 Days 27 If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Ed Jensen  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

**SUPPLEMENTARY**

27464