

No. 4
1-2-43
5-17-39
X3597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 20 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27474

State File No. _____

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:
1511 W. 20th Street
(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)

In this community 40 years

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. 1511 W. 20th St. **5**
(If rural, give location) **0**

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

If yes, name country _____

3. (a) PRINT FULL NAME Eva Leona Howell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7 year 1946 hour 6 minute A M.

21. I hereby certify that I attended the deceased from 1942 to July 7 1946, and that death occurred on the date and hour stated above.

(that I last saw her alive on July 6 1946, 19__)

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased: September 11, 1873
(Month) (Day) (Year)

Immediate cause of death myocarditis. Duration **..**

8. AGE: Years 72 Months 9 Days 26 If less than one day _____ hr. _____ min.

Due to nephritis **several months**

Due to _____

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

Other conditions none
(Include pregnancy within 3 months of death)

10. Usual occupation Housekeeper

11. Industry or business Home

Major findings: Of operations None

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

12. Name George Carter

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

14. Maiden name Mary Mullens

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

16. (a) Informant Mrs. Grace Lohr

(b) Address 1511 W. 20th St; Joplin; Mo

17. (a) Burial (b) Date thereof 7-9-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Park

18. (a) Signature of funeral director Parker Hunsaker

(b) Address 1502 Joplin, Joplin, Mo.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No.

(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) Manner of injury _____

19. (a) 7-11-46 (b) [Signature]
(Date received from registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) _____

Address 11500 Bldg. Date signed 7/10/46

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

MOTHER FATHER

138

(Licensed Embalmer's Statement on Reverse Side)

46-7-648

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 Josephine 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.

Registration District No. 156

Primary Registration District No. 201

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 NAME Eva L. Howell

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 wid

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

7. Birth date of deceased Sept 11
(Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days 20 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) _____
(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 _____ year 1976 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 Chronic hepatitis

Other conditions _____
(Include pregnancy within 6 months of death)

Major findings:
Of operations _____

Of autopsy 131/11

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 _____

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

SUPPLEMENTARY

26313

27474