

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:
St. John Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 1/2 Days (Specify whether
In this community 25 years (Specify whether
years, months or days)

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") 5
(d) Street No. 1330 Minnesota
(If rural, give location)
(e) Citizen of foreign country? N (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME

Anna Scofield

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 S. 0

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

7. Birth date of deceased Unk own
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 75 hr. min.

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

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Unknown

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 Mrs. Allie Stogsdill

(b) Address 1429 W. 9th, Joplin, Mo.

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

(c) Place: burial or cremation Fairview Cemetery

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

(b) Address 1502 Joplin, Joplin, Mo

19. (a) 5-17-46 (b) Ch. Jones
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16
year 1946 hour 12: minute 30 P. M.

21. I hereby certify that I attended the deceased from _____ 19____
did not attend 19____
that I last saw h _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Failure
Due to Chronic Nephritis

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 A. W. Stogdill _____
Address 2114 Joplin _____ Date signed 7/16/46

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

MOTHER FATHER

46 - 7 - 662

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.