

No. 2
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9665**

FILED MAR 28 1947

Primary Registration District No. **2001**

Registrar's No. _____

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

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:
517 Sergeant Ave
(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)

12 years

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. **517 Sergeant**
(If rural, give location)

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

If yes, name country _____

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3. (a) PRINT FULL NAME **Letitia S. Montee**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **6th**
year **1947** hour **3** minute **32 p** M.

4. Sex **Female** 5. Color or race **white**

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

6. (b) Name of husband or wife **James W.**

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

7. Birth date of deceased **August 12 1873**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **March 1, 1947, to March 6, 1947**; that I last saw **her** alive on **March 6, 1947**; and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage.**
(Apoplexy)

Duration
?

8. AGE:	Years	Months	Days	If less than one day
	73	6	21	hr. min.

Due to _____

Due to **Hypertension.**

?

9. Birthplace **Jacksonville Illinois**
(City, town, or county) (State or foreign country)

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

10. Usual occupation **Housewife**

Major findings: _____
Of operations _____

MOTHER FATHER {

12. Name **George E. Kennedy**

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

14. Maiden name **Sara J. Reaugh**

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

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs George H. Carroll**

(b) Address **517 Sergeant Ave**

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

(a) Accident, suicide, or homicide (specify) _____

17. (a) **Burial** (b) Date thereof **Mar 8, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence _____

(c) Place: burial or cremation **Ozark Memorial Park**

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

18. (a) Signature of funeral director **Thornhill-Dillon**

(b) Address **Joplin, Missouri.**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) Means of injury **G**

19. (a) **7-7-47** (b) **Ed J. Jones**
(Date received local registrar) (Registrar's signature)

23. Signature **Ed J. Jones** (M. D. or other) _____

Address **Joplin, Missouri.** Date signed **4-7-47**

47-3-209

12/1/20

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..... *David Dillon*
Licensed Embalmer No. *3898*
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.