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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 26 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17867

State File No.

Registration District No. 155

Primary Registration District No. 5579

Registrar's No. 75

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town rural - MINERAL TOWNSHIP.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Webb City - RURAL. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution entire life (Specify whether years, months or days)

In this community entire life (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. 512 W. 11 th.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country.....

3. (a) PRINT FULL NAME Mable Florence Long

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8
year 1947 hour 2:45 minute A M.

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 4, 1901
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 5, 1947 to May 8, 1947, that I last saw her alive on May 7, 1947, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

45 7 4 hr. min.

Immediate cause of death Chronic Myocarditis Duration do not know

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

Due to.....
Due to.....

10. Usual occupation Housekeeper

11. Industry or business own home

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

MOTHER FATHER { 12. Name Henry Childs

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

14. Maiden name Emma Cook

15. Birthplace no record 9
(City, town, or county) (State or foreign country)

Major findings: Of operations 930 PHYSICIAN

Of autopsy.....

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Ida Stamber

(b) Address 512 W. 11th, Joplin, Mo.

17. (a) Burial (b) Date thereof 5-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Date of occurrence.....

(c) Place: burial or cremation Fairview

18. (a) Signature of funeral director Parker Hunsaker

(b) Address 1502 Joplin, Joplin, Mo.

(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 2

19. (a) MAY 10, 47 (b) Paul C. Critchett, M.D.
(Date received local registrar) (Registrar's signature)

23. Signature P. C. Johnson (M. D. or other) D. O.
Address Webb City, Mo Date signed 5-9-47

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

47-5-420

2001 8 100

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 75-

Registration District No. 155 Primary Registration District No. 5579

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Rural
(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 Mable F. Long

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

4. Sex F 5. Color or race N 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 (Month) 2 (Day) 1947 (Year)

8. AGE: Years 45 Months _____ Days _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) MAY 10-1947 (b) [Signature]
(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 1947 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 _____

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 _____

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

17867