

FILED NOV 22 1947  
Registration District No. 196

Primary Registration District No. 2001

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  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days) Entire life

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. 512 W. 14th St.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Eliza Jeemes Shimmin  
3. (b) If veteran, name war ..... 3. (c) Social Security No. ....  
4. Sex F. / 5. Color or W. race. W. 6. (a) Single, widowed, married, divorced. W. 2  
6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased December 10, 1871  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. day 17 year 1947 hour 7 minute 30 P M.  
21. I hereby certify that I attended the deceased from Sept 1-47 to Sept 17, 1947 that I last saw her alive on Sept 17, 1947 and that death occurred on the date and hour stated above.

8. AGE: Years 75 Months 9 Days 7 If less than one day hr. min.  
9. Birthplace Dade County Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Own Home

Immediate cause of death Acute myocardial failure  
Due to Chronic myocarditis  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations A 3 B  
Of autopsy

MOTHER FATHER  
11. Industry or business .....  
12. Name .....  
13. Birthplace .....  
14. Maiden name .....  
15. Birthplace .....  
16. (a) Informant Mrs. Geltz J. Zentner  
(b) Address 601 No. Eyers, Joplin, Mo.  
17. (a) Burial (b) Date thereof 9-19-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Carterville Cemetery  
18. (a) Signature of funeral director Parker-Hunsaker  
(b) Address Joplin, Missouri  
19. (a) 9-18-47 (b) Salores Lampkin  
(Date received local registrar) (Registrar's signature)

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? (Specify type of place)  
While at work? (Specify means of injury)  
23. Signature Ernest Mitchell, D. or other M.D.  
Address Joplin Mo. Date signed 9-19-47

Duration 3 Wk  
?   
PHYSICIAN  
Underline the cause of which death should be charged statistically.

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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. 200

Registration District No. 15-6

Primary Registration District No. 200

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Jasper  
(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

Elyja J. Shemin

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 \_\_\_\_\_

7. Birth date of deceased Dec 10 1910  
(Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ min.)

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

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)

(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 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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

38083