

No. 2
147
17-39

39044

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

National Office of Vital Statistics

FILED DEC 9 1947
Registration District No. 244

Primary Registration District No. 2001-5835

Registrar's No.

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Rural---4402 Wall, R#4
(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 70 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73
(c) City or town Rural R#4, 4402 Wall 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Mitchell Gielt

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

4. Sex M. 0 5. Color or 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 October 20, 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 11 27 hr. min.

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

10. Usual occupation Retired

11. Industry or business

12. Name Edward Gielt 9

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

14. Maiden name Mary McCoy

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

16. (a) Informant Mr. J. F. Gielt
(b) Address 4402 Wall, Joplin, Mo.

17. (a) Burial (b) Date thereof 10-20-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hornet Cemetery Parker-Hunsaker

18. (a) Signature of funeral director Joplin, Missouri
(b) Address Joplin, Missouri

19. (a) 10-21-47 (b) Delores Samelinski
(Date received local registrar) (Registrar's signature) 1 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17
year 1947 hour 7 minute 35 PM.

21. I hereby certify that I attended the deceased from Sept 1 1947 to Oct 17 1947
that I last saw him alive on Oct 17 1947
and that death occurred on the date and hour stated above. Duration

Immediate cause of death Cardiac Failure
Hypertensive Pneumonia

Due to Coronary Arteriosclerosis
Due to Coronary Arteriosclerosis

Other conditions (include pregnancy within 3 months of death) 12 30

Major findings: Of operations 12 30
Of autopsy 12 30

PHYSICIAN
Underline the cause of 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 10/18/47 (Specify type of place) (By means of injury) 2

23. Signature W. B. Bennett (M. D. or other) 20
Address 2114 Joplin Date signed 10/18/47

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

MOTHER FATHER

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 Steve Parker

Licensed Embalmer No. 2348

P. O. Address Jephi 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

Zlot

State File No.

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Blue Springs
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Shoal Creek Trussp.
(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

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 _____

3. (a) PRINT FULL NAME James Mitchell Galt

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

4. Sex M 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 Oct 20 1920
(Month) (Day) (Year)

8. AGE: Years 82 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 19 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 _____

Due to _____

Due to _____

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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?
_____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

39044