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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 26 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44411**

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's**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 day** (Specify whether years, months or days)

In this community **1 day**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Cherokee**

(c) City or town **Baxter Springs**
(If outside city or town limits, write "RURAL")

(d) Street No. **505 Washington**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **PAULETTE WALTER**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **1** year **1947** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **11-30** 19**47** to **12-1** 19**47**
that I last saw her alive on **11-30** 19**47**
and that death occurred on the date and hour stated above.

4. Sex **F** 5. Color or race **Wh**

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

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

7. Birth date of deceased: **Nov** **30** **1947**
(Month) (Day) (Year)

Immediate cause of death **Prematurity**

Due to **(7 mo baby)**

Due to **(wt 3 lbs 13 oz)**

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

8. AGE: Years _____ Months **1** Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **Infant**

11. Industry or business _____

Major findings: Of operations _____

Of autopsy **159**

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

MOTHER FATHER { 12. Name **PAUL M. WALTER**

13. Birthplace **RUSHFORD N.Y.**
(City, town, or county) (State or foreign country)

14. Maiden name **MERCY T. DENTON**

15. Birthplace **SOUTHAMPTON ENGLAND**
(City, town, or county) (State or foreign country)

16. (a) Informant **Paul M. Walter**

(b) Address **Baxter Springs, Mo.**

17. (a) **Burial** (b) Date thereof **12-2-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Baxter Spgs. Cemetery**

18. (a) Signature of funeral director **J. K. Kline**

(b) Address **Baxter Springs, Kansas**

19. (a) **12-1-47** (b) **Dolores Hampton**
(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? _____

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

23. Signature **T. H. Bogan** (M. D. or other) **MD**
Address **Baxter Springs, Mo.** Date signed **12-1-47**

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

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 Kex N. Shewmake

Licensed Embalmer No. 1998

P. O. Address. East St. Louis, 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.

44411
Feb

State File No. _____

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town _____
 (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 _____ (Specify whether _____)
 years, months or days)

3. (a) PRINT FULL NAME

Paulette Walter

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 S

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

7. Birth date of deceased mm. 30 live _____
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (if less than one day) _____
 hr. _____ 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 _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-11-47 (b) Delores Simpson, R.
 (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 94 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her 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 _____

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

SUPPLEMENTARY

S-44411