

FILED JAN 17 1948
Registration District No. **156-244**

Primary Registration District No. **2-5834**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Newton**
(b) City or town **Rt 4, Joplin**
(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
Lifetime)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Newton**
(c) City or town **Rt 4, Joplin**
(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 **Clara Louise Paul**

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

4. Sex **female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **widow**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **December 11 1870**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 11 17 hr. min.

9. Birthplace **Spurgeon Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business **housewife**

12. Name **Adam Kraft**

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

14. Maiden name **Louisa Kercher**

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

16. (a) Informant **Clarence Paul**

(b) Address **Rt 4, Joplin, Mo**

17. (a) **Burial** (b) Date thereof **Dec 3-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Burkhart Cemetery**

18. (a) Signature of funeral director **Thornhill-Dillon Mort**
Joplin, Missouri

(b) Address _____
19. (a) **12-2-47** (b) **Selmer Lamkins**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **28th**
year **1947** hour **4** minute **15p** M.

21. I hereby certify that I attended the decedent from **Nov 20** 19 **to** **Nov 20** 19 **47**
that I last saw her alive on **Nov 20** 19 **47**
and that death occurred on the date and hour stated above. *Duration*

Immediate cause of death **Coronary Occlusion**

Due to _____

Due to _____

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

Major findings: Of operations **CHD**

Of autopsy _____

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? _____ (Specify type of place)

While at work _____ (e) Means of injury _____

23. Signature **T. B. Duemler** (M. D. or other) _____

Address **Seveca Mo** Date signed **11-30-47**

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 *Edmund M. Dungey*

Licensed Embalmer No. *3066*

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.

44503
Met

No. 2B
1945
43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Joseph
(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 Clara L. Paul

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

4. Sex F 5. Color of 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 see 11
(Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 10 (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) _____ (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 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 _____

21. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY 5

S-44503