

No. 2  
-1/47  
17-39

Registration District No. **1812**

Primary Registration District No. **2111**

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

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 **2 days**  
(Specify whether years, months or days)

In this community **56 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JASPER 49**

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

(d) Street No. **2117 Connor Ave.**  
(If rural, give location)

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

3. (a) PRINT FULL NAME **DELLAH ELIZABETH BROOKSHIRE**

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **Fem.** 5. Color or race **Wh.** 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 **March 14th, 1867**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>80</b>	<b>11</b>	<b>14</b>	.....hr. ....min.

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

10. Usual occupation **Retired**

11. Industry or business **Housewife**

12. Name **George W. Gardner**

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

14. Maiden name **not available**

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

16. (a) Informant **Cecil C. Brookshire**

(b) Address **N. Main, Joplin, Mo.**

17. (a) **Burial** (b) Date thereof **3-2-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fairview**

18. (a) Signature of funeral director **Parker-Hunsaker**

(b) Address **Joplin, Mo.**

19. (a) **3-1-48** (b) **Silvers Sampkins**  
(Date received local registrar) (Registrar's signature)

Jefferson City Printing Co. (Licensed Embalmers' Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **28th**  
year **1948** hour **11:50** minute **P.** M.

21. I hereby certify that I attended the deceased from **1943**  
19....., 19....., to **Feb 28 1948** 19.....;  
that I last saw h.....er alive on **Feb 28 1948** 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Gastric hemorrhage** **2 days**

Due to **myocarditis.**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **none**  
**blood transfusions.**

Of autopsy

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

(a) Accident, suicide, or homicide (specify) **no**

(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) (Means of injury)

Signature **[Signature]** (M. D. or other)  
Address **Joplin Mo.** Date signed **3/2/48**

PHYSICIAN  
Underline the cause of which death should be charged statistically.  
**ADDITIONAL SUPPLEMENTARY PAGES**

936

**[Signature]**

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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.

Registration District No. 156

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:  
(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 Delilah E. Brookshue

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 \_\_\_\_\_ years

7. Birth date of deceased march 14 (Month) (Day) (Year)

8. AGE: Years 80 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)

(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 1948 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 Gastric Hemorrhage

Due to Unknown...

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

White at work \_\_\_\_\_ (Specify type of place) \_\_\_\_\_

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

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

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

SUPPLEMENTARY

S-9060

over ...  
L...  
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