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-47  
-39  
3906

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

33380

FILED OCT 25 1948

State File No. ....

Registration District No. 136

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 Hospital   
(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 Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler 12

(c) City or town Poplar Bluff 7  
(If outside city or town limits, write "RURAL")

(d) Street No. Unknown 3  
(If rural, give location)

(e) Citizen of foreign country? Unknown (Yes or No) 1  
If yes, name country \_\_\_\_\_

3: (a) PRINT FULL NAME William WASHINGTON

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

4. Sex Male  5. Color or race W

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

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

7. Birth date of deceased Unknown App 50 Yr  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9th.  
year 1948 hour 10:00 minute P. M.

21. I hereby certify that I attended the deceased from Oct 7 1948 to Oct 9 1948  
that I last saw him alive on Oct \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_  
8 \_\_\_\_\_

8. AGE: Years Months Days If less than one day

Approx. 50 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

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

10. Usual occupation Unknown

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 12. Name Unknown 7

{ 13. Birthplace Unknown (City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown

{ 15. Birthplace Unknown 7  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_ (26)

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

16. (a) Informant Joplin Police Dept.

(b) Address Joplin, Mo.

17. (a) Burial (b) Date thereof Oct. 12, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director Thornhill-Dillon

(b) Address 305 West 4th St. Joplin, Mo.

19. (a) 10-12-48 Edd James  
(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 \_\_\_\_\_

23. Signature E. C. Coates (M. D. or other) \_\_\_\_\_  
Address Joplin Mo. Date signed 10-12-48

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

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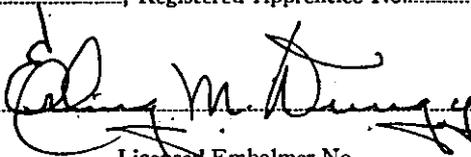
**STATEMENT BY LICENSED EMBALMER**

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



Licensed Embalmer No. 3566

P. O. Address Japan 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.**