

No. 300  
10.48

FILED MAR 17 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 8810

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BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 200 Registrar's No. 104

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JASPER	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN JOPLIN U)		c. CITY (If outside corporate limits, write RURAL and give township) JOPLIN 77 OR TOWN JOPLIN 2 5	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 50 JOHN'S HOSPITAL		d. STREET ADDRESS (If rural, give location) N.W. C. A.	
3. NAME OF DECEASED a. (First) MAE b. (Middle) CARSKADDON c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 3-2-49
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED (?)	8. DATE OF BIRTH 5-8-1884
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months 10 Days 22	IF UNDER 1 MRA. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Mother		10b. KIND OF BUSINESS* OR INDUSTRY Y. W. C. A.	11. BIRTHPLACE (State or foreign country) Humansville, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME No Record	
13b. MOTHER'S M maiden name No Record		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Chas. E. Carskaddon, 1115 Jackson		ADDRESS Joplin, Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Atherosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1201	
18. INTERVAL BETWEEN ONSET AND DEATH 24 hrs		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/1, 1949, to 3/2, 1949, that I last saw the deceased alive on 3/2, 1949, and that death occurred at 4:15A.M., from the causes and on the date stated above.			
23a. SIGNATURE J. A. ... (Degree or title)		23b. ADDRESS 420 Byers, Joplin, Mo.	
23c. DATE SIGNED 3/4/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-7-49	
24c. NAME OF CEMETERY OR CREMATORY Forest Park		24d. LOCATION (City, town, or county) Joplin Mo	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS BARKER-HUNSAKER MORTUARY, JOPLIN, MO	
DATE REC'D BY LOCAL REG. 3-5-49		REGISTRAR'S SIGNATURE Ed James 138	

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

(Licensed Embalmer's Statement on Reverse Side)

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*F. M. Jones*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 2319

P. O. Address Jefferson Ave

**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.