

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 8872

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26

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 3127 Registrar's No. 69

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 township) OR TOWN Webb City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Webb City	
c. LENGTH OF STAY (in this place) 5 yrs		d. STREET ADDRESS (If rural, give location) 401 N. Webb St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 401 N. Webb St.		4. DATE OF DEATH (Month) (Day) (Year) March 30, 1949	
3. NAME OF DECEASED (Type or Print) a. (First) EMMA b. (Middle) BELLE c. (Last) BLACK		5. SEX female	
6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, WIDOWED (Specify)	
8. DATE OF BIRTH Aug 15, 1872		9. AGE (In years last birthday) 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Joplin, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME NO DATA		13b. MOTHER'S MAIDEN NAME NO DATA	
14. NAME OF HUSBAND OR WIFE Albert Black		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. Ben Scott, 1917 Penn, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) chronic myocarditis  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) senility  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arthritis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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) m.		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 1947, to 3-30, 1949, that I last saw the deceased alive on 3-20, 1949, and that death occurred at 12:55 p.m., from the causes and on the date stated above.			
23a. SIGNATURE Dr. P. M. Pence		23b. ADDRESS D. O. L. Carterville, Mo	
23c. DATE SIGNED 3-31-49		24a. BURIAL, CREMATION, REMOVAL (Specify) burial	
24b. DATE April 1, 1949		24c. NAME OF CEMETERY OR CREMATORY Red Oak Cemetery	
24d. LOCATION (City, town, or county) (State) Lawrence County, Mo.		DATE REC'D BY LOCAL REG. APR. 4. 1949	
REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Knell Mortuary, Carthage, Mo	

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 Robert H. Knell.....

Signed.....  
Student Embalmer

Licensed Embalmer No. 4459.....

P. O. Address Carthage.....

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.