

# FEDERAL BUREAU OF INVESTIGATION FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-036609

FILED VS NOV 13 1959

STATE FILE NUMBER

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 531

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>JASPER</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>JASPER</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JOPLIN</b>	Length of stay in 1b <b>ALWAYS</b>	c. CITY OR TOWN <b>JOPLIN</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>FREEMAN HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1604 WALL ST.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>FLOSSIE</b> Middle <b>MAE</b> Last <b>JESTER</b>			<b>4. DATE OF DEATH</b> Month <b>NOVEMBER</b> Day <b>4</b> Year <b>1959</b>				
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12-21-1885</b>	<b>9. AGE (last birthday)</b> <b>73</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>HOME</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>JOPLIN, MO.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13a. FATHER'S NAME</b> <b>- REWBART</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>EMMA CRAIG</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>OLLIE L. JESTER</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>OLLIE L. JESTER, 1604 WALL ST.</b>		

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Aspiration</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coma</u> DUE TO (c) <u>Parkinson's Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 weeks</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21.</b> I attended the deceased from <u>11/7/56</u> to <u>11/4/59</u> and last saw her alive on <u>11/3/59</u> Death occurred at <u>8:15 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> (Degree or title) <u>A. K. Weisman MD</u>			<b>22b. ADDRESS</b> <u>301 Medical Arts Bldg</u> <u>Joplin, Mo.</u>		<b>22c. DATE SIGNED</b> <u>11-5-59</u>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	<b>23b. DATE</b> <u>11-6-59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>MT. HOPE CEMETERY,</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>WEBB CITY, MISSOURI</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>STEVE PARKER MORTUARY, JOPLIN, MO.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>11-10-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Dove Merriam</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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.

Student \_\_\_\_\_  
Signature of Student Embalmer

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. - -

If this body is not embalmed, fact should be so stated above.