

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

15179
Do not use this space.

MAY 18 1939

1. PLACE OF DEATH

(a) County Jasper Registration District No. 411
 (b) Township Poplin Primary Registration District No. 2002 Registered No. _____
 or _____
 (c) City Poplin (d) Street No. 1115 Valley St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 1115 Valley St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Pitts
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 11-1865
 7. AGE YEARS 74 MONTHS 1 DAYS 7 IF LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Janitor
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-18-39
 22. I HEREBY CERTIFY, That I attended deceased from 3/29/38, 19____, to 4/18/39, 19____
 I last saw him alive on 4/18/39 Death is said to have occurred on the date stated above, at 7:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Chronic Passive Congestion of Lung
Pulmonary Abscess

Other contributory causes of importance:

Arteriosclerosis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Texas

FATHER

13. NAME Arthur Pleasant

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no record

MOTHER

15. MAIDEN NAME Elise Johnson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas

17. INFORMANT (ADDRESS)

Frank Pitts
Poplin

18. BURIAL, CREMATION, OR REMOVAL

PLACE PARWAY CEM DATE 4-22-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

Furendall
Poplin

20. FILED

4-28-39 Ed B. Jumper
Local Registrar

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) J. B. Chatman, M. D.
 (Address) 106 N. Main

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 6,

District File Number

6-5-39-1108

Date Filed

MAY 15 1939

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.....

James K. Fairbank

Licensed Embalmer No.....

959

P. O. Address.....

Japan Hill

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, above space should be left blank.

COPY

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

15-179
Do not use this space.

1. PLACE OF DEATH
 (a) County Jasper Registration District No. 411
 (b) Township _____ Primary Registration District No. 2002
 (c) City Joplin (d) Street No. _____ Registered No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Harry Otter
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE Blk 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 11 7
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____
 19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-18 1939
 22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
 I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Chronic Passive Congestion of Lungs
Pulmonary Hemorrhage
Aspiration Pneumonia (Coke)
 Date of onset 10/8
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) J. E. Swotman, M. D.
 (Address) 106 W. Main

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

