

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 411 Primary Registration District No. 2002 Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Jasper

(b) City or town Joplin Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2401 Penn.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 5 YEARS.  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jasper

(c) City or town Joplin  
(If outside city or town limits, write "RURAL")

(d) Street No. 2401 Penn.  
(If rural, give location)

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

**3. (a) PRINT FULL NAME** MRS IDA M. WILSON

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

4. Sex Fem. 5. Color or race W.

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

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

7. Birth date of deceased May 19, 1866  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept day 18  
year 1941 hour 8 minute 40 A. M.

21. I hereby certify that I attended the deceased from April - 9<sup>th</sup> 1941 to September 18, 1941;  
that I last saw her alive on September 18, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 3 hrs

**8. AGE:**

Years	Months	Days	If less than one day
<u>75</u>	<u>3</u>	<u>29</u>	hr. _____ min. _____

Due to hypertensive cardio-vascular disease 12-15 yrs

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

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

10. Usual occupation house wife

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

Major findings: none

Of operations none

Of autopsy none

**MOTHER FATHER**

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

12. Name William Murray

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

14. Maiden name Mary Pruitt

15. Birthplace Mo  
(City, town, or county) (State or foreign country)

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Mark Farrar

(b) Address 2401 Penn Joplin, Mo

17. (a) Removal (b) Date thereof Sept 19, 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cameron, Mo.

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

(b) Address Joplin, Mo.

19. (a) 9-18-41 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

**22. If death was due to external causes, all 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 O. T. Elmerke (M. D. or other) [Signature]  
Address 607 Main, Joplin, Mo. Date signed 9-18-41

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

41-10-857.

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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..... *David Dillon* .....

Licensed Embalmer No..... *3898* .....

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