

Dr. Tol.
 2587
 Do not use this space.

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

722
 FILED FEB 13 1949

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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1. PLACE OF DEATH
 (a) County Jasper Registration District No. 15-6
 (b) Township _____ Primary Registration District No. 2001 Registered No. 614 991
 (c) City Joplin (d) Street No. 1st St. Johns Hospital St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. 15 (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Cora B. Sanders
 (a) Residence, No. 576 Mar 801 St. Baxter Springs Mo
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Eugene Joseph Sanders

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 17, 1896

7. AGE YEARS 46 MONTHS _____ DAYS _____ If LESS than 1 day,hrs. ormin.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Keeper

9. Industry or business in which work was done, as saw mill, bank, etc. at Home

10. Date deceased last worked at this occupation (month and year) 10 days 11. Total time (years) spent in this occupation 5 year

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chickamauga Texas 1

13. NAME Romas G. Compton

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas 1

15. MAIDEN NAME Weekman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas 1

17. INFORMANT Eugene J Sanders (ADDRESS) Baxter Springs Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Deacons Mts DATE Jan 17 1949

19. FUNERAL DIRECTOR (NAME) Harveys (ADDRESS) Baxter Springs Mo

20. FILED 1-16-49 Hettie D. Dredhoffer Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 15 1949

22. I HEREBY CERTIFY, That I attended deceased from Jan 11 1949 to Jan 15 1949
 I last saw him alive on Jan 16 1949. Death is said to have occurred on the date stated above, at 11:15 AM.
 The principal cause of death and related causes of importance were as follows:
Menstrual poisoning from acute infectious depression
 Date of onset over 2 weeks

Other contributory causes of importance:
Chronic arteriosclerosis of nephritis

Name of operation 1318 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. B. Chilton, M. D.
 (Address) Joplin Mo

48-1-59

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.....

J. R. Rine....., Registered Apprentice No. *1188*
working under my personal supervision.

Signed.....

Licensed Embalmer No. *1188*

P. O. Address. *East Springs Co*

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.