14604

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

LED MAY 13 1943

Registration District No. 15F6 Primary Registration District No. 2001 Registrar's No. 248

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

1. PLACE OF DEATH:

(a) County JASPER

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

(c) Name of hospital or institution: FREEMAN HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 DAYS (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEWTON

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

(d) Street No. W. SPRING STREET (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country /

3. (a) PRINT FULL NAME JAMES FREDRICK WILLS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MALE

5. Color or race White

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

6. (b) Name of husband or wife Lilly Wills

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Apl (Month) 28 (Day) 1868 (Year)

8. AGE: Years 75 Months Days 1 If less than one day hr. min.

9. Birthplace Neosho (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation Merchant

11. Industry or business Retired

FATHER
12. Name LEWIS WILLS
13. Birthplace Tennesee (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Jane Spaan
15. Birthplace Tennesee (City, town, or county) (State or foreign country)

16. (a) Informant Mrs A. F. Wills

(b) Address Neosho Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-29-43 (Month) (Day) (Year)

(c) Place: burial or cremation Neosho MISSOURI

18. (a) Signature of funeral director [signature]

(b) Address Neosho MISSOURI

19. (a) 4-20-1943 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29 year 1943 hour 3 minute 50 p. M.

21. I hereby certify that I attended the deceased from April 19 1943 to April 29, 1943 that I last saw him alive on April 29, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Chronic Heart failure

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Prostate Resection April 29-1943

Of autopsy

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address [signature] Date signed 4-30-43

(Licensed Embalmer's Statement on Reverse Side)

43-4-429

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 J. C. Bingham

Licensed Embalmer No. 2689

P. O. Address Neosho 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.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14604

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 248

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jasper

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

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

(d) Length of stay: In hospital or institution 5 da (Specify whether

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Newton

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

(d) Street No. W. Spring (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME James F. Wills

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased April (Month) 28 (Day) 1868 (Year)

8. AGE: Years 75 Months — Days If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

12. Name .....

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

14. Maiden name .....

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

16. (a) Informant .....

(b) Address .....

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

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29 year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h..... alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis chronic Heart failure

Due to .....

Due to 51 h

Other conditions ..... (Include pregnancy within 3 months of death)

Major findings: Of operations Prostate resection April 29-1943

Of autopsy Lab Report 2 weeks Lath Malignant

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) .....

(b) Date of occurrence .....

(c) Where did injury occur? ..... (City or town) (County) (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)

While at work? ..... (c) Means of injury .....

23. Signature [signature] (M. D. or other) .....

Address Salem Mo. Date signed .....

S-14604