

FILED FEB 11 1946

Registration District No. **2001** Primary Registration District No. **2001**

1. PLACE OF DEATH:  
(a) County Jasper  
(b) City or town Joplin  
(c) Name of hospital or institution: 306 Pearl  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution All life  
(Specify whether 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. 306 Pearl  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Albert T. Whitwell  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 491-01-4240

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January day 17 year 1944 hour 7:10 P. Minute M.  
21. I hereby certify that I attended the deceased from 1 - 1943 to 1 - 17 1944  
that I last saw him alive on 1 - 17 1944  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Marie 6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased December 10, 1873  
(Month) (Day) (Year)

Immediate cause of death Cardiac Failure  
Duration \_\_\_\_\_

8. AGE: Years 70 Months 1 Days 7 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to Arterio Sclerosis  
Due to Acute Nephritis  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Joplin Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Blacksmith  
11. Industry or business \_\_\_\_\_  
12. Name James T. Whitwell  
13. Birthplace Tennessee  
(City, town, or county) (State or foreign country)  
14. Maiden name Orpha Carmin  
15. Birthplace Indiana  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Ombertine  
(b) Address 306 Pearl, Joplin, Mo.  
17. (a) Burial (b) Date thereof 1-19-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Ozark Memorial Park  
18. (a) Signature of funeral director Hurlbut Und. Co.  
(b) Address Joplin, Missouri  
19. (a) 1-18-44 (b) Justine Sudhorst  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature D. J. McGowan (M. D. or other) DD  
Address 2114 S. Joplin, Joplin, Mo. Date signed 1-18-44

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

44-50

07-10-1924

**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 *Terry T. Paulsen*

Licensed Embalmer No. *959*

P. O. Address *Spokane, Wn*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb.

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

**1. PLACE OF DEATH:**

(a) County Jasper

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

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

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

In this community \_\_\_\_\_  
years, months or days

**3. (a) PRINT FULL NAME** Albert T. Whitwell

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 491-01-4240

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased Dec. 10, 1903  
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan Day 15 Year 1944 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Cardiac disease  
Uremic poisoning  
Acute nephritis  
Due to Chronic nephritis

Other conditions Arteriosclerosis Jun. 1943  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature P. G. Martin (Physician or other) \_\_\_\_\_  
Address 2114 24<sup>th</sup> St. Joplin Mo. Date signed 2-15-44

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

**SUPPLEMENTARY**

3272