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X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED SEP 23 1944**

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

089-7-44  
311721  
State File No. \_\_\_\_\_  
Registrar's No. 443

Registration District No. 156

Primary Registration District No. 2001

1. PLACE OF DEATH:  
(a) County Jasper  
(b) City or town Joplin  
(c) Name of hospital or institution: St. John's Hospital  
(d) Length of stay: In hospital or institution 12 days  
In this community 35 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jasper  
(c) City or town Joplin  
(d) Street No. 1407 E. "G" Street  
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME Nellie Ann Smith  
3. (b) If veteran, name war none  
3. (c) Social Security No. none

20. DATE OF DEATH: Month Sept. day 11  
year 1944 hour 1 minute 40P M.

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife George W. Smith  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased September 17, 1872

21. I hereby certify that I attended the deceased from Sept 8, 19\_\_\_\_, to Sept 11, 19\_\_\_\_;  
that I last saw him alive on Sept 11, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
71 11 24 hr. min.

Immediate cause of death:  
Cardiovascular Renal Division - hypertension  
Due to Chronic Br. asthma

9. Birthplace Livingston county, Kentucky  
10. Usual occupation housewife

Other conditions (Include pregnancy within 3 months of death)  
131a

11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_

Major findings: Of operations 131a  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. George W. Smith  
(b) Address 1407 E. "G", Joplin, Missouri  
17. (a) burial (b) Date thereof 9/14/44  
(c) Place: burial or cremation Fairview Cemetery

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director PARKER-HUNSAKER  
(b) Address 1502 Joplin, Joplin, Missouri  
19. (a) 9-14-44 (b) Arthur Hunsaker

While at work? \_\_\_\_\_ (Specify type of place)  
(2) Means of injury 0  
23. Signature A. L. Crawford (M. D. or other) \_\_\_\_\_  
Address Joplin Mo Date signed \_\_\_\_\_

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

1204

(Licensed Embalmer's Statement on Reverse Side)

9-12-44

44-9-730

SEP 25 1944

976 LG ME

**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 F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. Oct

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. 243

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

4. Sex ♂ 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased: Sept 17 1878  
(Month) (Day) (Year)

8. AGE: Years 71 Months 11 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 No data  
13. Birthplace No data (City, town, or county) (State or foreign country)  
14. Maiden name No data  
15. Birthplace No data (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) 10-9-44 (b) Justus Sudholz  
(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 Sept Year 1944 Hour 10 minute 15 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 \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

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) (c) Means of injury \_\_\_\_\_

25. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

(111) 27 1945

MAY 4 1945

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