

FILED DEC 11 1944

Registration District No. 26

Primary Registration District No. 2001

1. PLACE OF DEATH  
**Jasper**  
(a) County Joplin  
(b) City or town Joplin  
(c) Name of hospital or institution DePue Hospital  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: In hospital or institution 9 Days  
In this community Life years, months or days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Newton 73  
(c) City or town Diamond 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location) No.  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 1  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Clara Jane Whitwell  
(b) If veteran, name war No  
(c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 17  
year 1944 hour 8 minute 15 A.M.

4. Sex F  
5. Color or race W  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife James T.  
6. (c) Age of husband or wife if alive Deceased years 18 1854

21. I hereby certify that I attended the deceased from Nov 8 1944 to Nov 17 1944.  
that I last saw her alive on November 17 1944.  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cardiac Failure Duration \_\_\_\_\_

7. Birth date of deceased: September (Month) 18 (Day) 1854 (Year)  
8. AGE: Years 90 Months 1 Days 30 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to Uremic poisoning  
Due to Cerebral Hemorrhage  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Troy Ohio (City, town, or county) (State or foreign country) 1  
10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name Benjamin Carman  
13. Birthplace Lanesville Ohio (City, town, or county) (State or foreign country) 1  
14. Maiden name Clementine Jenkins  
15. Birthplace Troy Ohio (City, town, or county) (State or foreign country) 1

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Marie Prochaska  
(b) Address Diamond Missouri  
17. (a) Burial (b) Date thereof 11-19-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Diamond Cem  
Hurlbut Und Co.  
18. (a) Signature of funeral director Joplin, Mo.  
(b) Address \_\_\_\_\_  
19. (a) 11-19-44 (b) Arthur S. Sudduth  
(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 Dr. E. Martin (M. D. or other) 2  
Address 506-7 Prince Bldg Date signed 11-18-44

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

MOTHER FATHER

1204

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

*Ferris Hurlbut*

Licensed Embalmer No. 959

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.

Registration District No. 56

Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Jackson  
(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 Clara J. Whitwell

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased sent 18 1951  
(Month) (Day) (Year)

8. AGE: Years 90 Months 1 Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

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 July 1951 year. 7 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 1951 \_\_\_\_\_ 1951 \_\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 1951 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to chronic arteriosclerosis

Due to Cerebral Hemorrhage

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

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 1318  
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 D. E. Martin (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

38075