

No. 2
2-43
5-17-39
K35697

State File No. _____

FILED FEB 13 1947

Register District No. _____

Primary Registration District No. 2001

Registrar's No. _____

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 St. Johns Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 days (Specify whether
 In this community 40 years 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. 1724 Penn Ave (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Clara Valger

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 married

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

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

7. Birth date of deceased December 18-1860
 (Month) (Day) (Year)

8. AGE:

Years 86

Months 0

Days 16

If less than one day hr. _____ min _____

9. Birthplace

Berlin
(City, town, or county)

Wisconsin
(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

Housewife

12. Name

Gam Alexander

13. Birthplace

Germany
(City, town, or county)

Germany
(State or foreign country)

14. Maiden name

Delia Cohen

15. Birthplace

Chicago
(City, town, or county)

Illinois
(State or foreign country)

16. (a) Informant

Ralph R. Valger

(b) Address

1724 Penn Ave

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Jan 8-47
(Month) (Day) (Year)

(c) Place: burial or cremation

Mount Hope Cemetery

18. (a) Signature of funeral director

Thornhill-Dillon

(b) Address

Joplin Missouri

19. (a) 1-6-47

(Date received local registrar)

(b) Ed Danner

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 3
 year 1947 hour 6 minute 20p. M.

21. I hereby certify that I attended the deceased from Jan 25, 1946 to Jan 17, 1947

that I last saw her alive on 1/3 and that death occurred on the date and hour stated above.

Immediate cause of death

Myocarditis
hepatic

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy _____

Duration

Several Months

PHYSICIAN

ADDITIONAL

SUPPLEMENT

INFORMA

REQUEST

Indicate the cause of death which should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) no
 (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?

Where at _____

(Specify type of place)

(a) Means of injury _____

23. Signature

[Signature] (M. D. or other) _____
 Date signed 1/4/47

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

47-133

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..... *David Dillon*.....

Licensed Embalmer No. *3898*.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jet

Registration District No. 156

Primary Registration District No. 2051

Registrar's No. _____

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 Clara Valper

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 _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Dec 18 1878
(Month) (Day) (Year)

8. AGE: Years 86 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (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 _____ Year 1967 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to Senility

Due to _____

Other conditions _____ (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 Dr. Michael S. [unclear] (M.D. or other) _____
Address Joplin Mo Date signed _____

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

SUPPLEMENTARY

S-1334