FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 44501

FILED JAN 17 1948

Registration District No. 1-26 244 Primary Registration District No. 20-01 5834 Registrar's No.

1. PLACE OF DEATH:
(a) County Newton
(b) City or town Rural #3
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Joplin
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 25 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Newton 73
(c) City or town Rural #3
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Emaline Roberts Bresee
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 M.
6. (b) Name of husband or wife Charles
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 9, 1921 (Month) (Day) (Year)

8. AGE: Years 26 Months 5 Days 11 If less than one day hr. min.

9. Birthplace Lawrence, Kansas (City, town, or county) (State or foreign country)
10. Usual occupation own home
11. Industry or business
FATHER
12. Name Lewis Roberts
13. Birthplace Buffalo, Missouri (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Frances McCoy
15. Birthplace Bonner Springs, Kansas (City, town, or county) (State or foreign country)
16. (a) Informant Frances Roberts
(b) Address 701 No. Maiden Lane, Joplin
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22 47 (Month) (Day) (Year)
(c) Place: burial or cremation Fairview
18. (a) Signature of funeral director Parker-Hunsaker
(b) Address Joplin, Missouri
19. (a) 11-24-47 (Date received local registrar) (b) Dolores Lamplin DR (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20 year 1947 hour 1 minute 00 A M.
21. I hereby certify that I attended the deceased from Oct. 31, 1947, to Nov. 18, 1947, that I last saw her alive on Nov. 18, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to

Due to

Other conditions Ninth month of Pregnancy
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause of 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 C C Coal (M. D. or other)
Address Joplin Mo Date signed 11-20-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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

47-12-1015

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 44501

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Rural - R 3 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 years, months or days)

In this community _____

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 _____

3. (a) PRINT FULL NAME Emaline R. Breece

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 M

6. (b) Name of husband or wife _____

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

7. Birth date of deceased June 9 1878 (Month) (Day) (Year)

8. AGE: Years 26 Months 5 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name _____

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

MOTHER 14. Maiden name _____

MOTHER 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 _____ Day _____ year 1944 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 _____ — Duration

Due to _____

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? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

S-44501