

FILED MAY 5 1948
Registration District No. 156

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

13113

State File 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:
931 1/2 Main Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... 50 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49
(c) City or town Joplin
(If outside city or town limits, write "RURAL")
(d) Street No. 931 1/2 Main Street 5
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME DANIEL RICHARD WALSH

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

4. Sex Male () 5. Color or race White 6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife Marjorie Walsh 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased February 22, 1875
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 3 If less than one day hr. min

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

10. Usual occupation Machinist

11. Industry or business Eagle-Picher

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant Mrs. Marjorie Walsh 7

(b) Address 931 1/2 Main

17. (a) Burial Burial (b) Date thereof 3-26-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ozark Memorial

18. (a) Signature of funeral director Parker-Hunsaker

(b) Address 1502 Joplin Street

19. (a) 3-27-48 (b) D. L. Sampson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22
year 1948 hour 11 minute 53 P.M.

21. I hereby certify that I attended the deceased from March 22,
1948, to..... 19.....
that I last saw him alive on March 22, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion 2 hrs

Due to.....

Due to.....

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

Major findings: Of operations 940
Of autopsy.....

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?.....

While at work?..... (Specify type of place)

23. Signature of physician Chas. B. Coyne (e) Means of injury 2

Address 619 Erie St. Joplin Mo. Date signed 3/25/48

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

MOTHER FATHER

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may
Registrar's No. _____

Registration District No. 156

Primary Registration District No. 2001

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)

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..... Daniel R. Walsh

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..... m

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

7. Birth date of deceased..... Feb 22
(Month) (Day) (Year)

8. AGE: Years..... 73 Months..... Days..... (less than one day)
hr. min.

9. Birthplace..... Kansas
(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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... March 22
year..... 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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)
(e) Means of injury.....

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

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-13113