

No. 300
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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED JUL 15 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19871

Registration District No. 156

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 4 weeks
(Specify whether years, months or days)

In this community Lifetime

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. 2411 W. 13th. St
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME AGNES MARGARET WATERMAN

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife L.H. Waterman

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased August 5 1884
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day	
<u>63</u>	<u>9</u>	<u>23</u>	hr.	min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name No record

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

14. Maiden name No record

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

16. (a) Informant L. H. Waterman

(b) Address 2411 W. 13th. Joplin, Mo

17. (a) Burial (b) Date thereof 5-29-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Park, Joplin, Mo

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

(b) Address 1502 Joplin, Joplin, Missouri

19. (a) 6-4-48 (b) Dalores Sampson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28th
year 1948 hour 12 minute 05 AM

21. I hereby certify that I attended the deceased from April 22, 1948, 1948, to May 28, 1948, that I last saw h. er. alive on May 28, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure

Due to Massive coronary occlusion

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 _____

Signature Selcourse M.D. or other _____

Address 308 Frisco Bldg. Joplin, Mo Date signed 6/2/48

Duration 6 wks.

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

OCT 5 1956

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 *Jefferson 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. 156

Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Gasconade
(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) (Specify whether

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 Agnes M. Waterman

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 _____

7. Birth date of deceased Aug 5 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (If less than one day, hr. _____ min. _____)

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-4-48 (b) Dolores Sampson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ 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 _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-1987/