

FILED JUN 10 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16953

State File No. 16953
Warrant No. 245
Registrar's No. 245

BIRTH NO. _____ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 2001

495

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

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) Joplin		c. CITY (If outside corporate limits, write RURAL and give township) Joplin	
c. LENGTH OF STAY (in this place) 45 yrs		d. STREET ADDRESS (If rural, give location) 320 Moffet	
d. FULL NAME OF HOSPITAL OR INSTITUTION 320 Moffet			

3. NAME OF DECEASED (Type or Print) a. (First) Leroy	b. (Middle) Sunderland	c. (Last) Dewey	4. DATE OF DEATH (Month) (Day) (Year) May 31, 1952
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 22, 1869	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney at Law	10b. KIND OF BUSINESS OR INDUSTRY same	11. BIRTHPLACE (State or foreign country) Crawford, Maine	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James Dewey	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Katharine Dewey
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Katharine Dewey, 320 Moffet	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH ?
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pernicious anemia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 2900	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 5-9 1952 to 5-31 1952 that I last saw the deceased alive on 5-27 1952 and that death occurred at 7:25 PM from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title)	23b. ADDRESS Frisco Bldg. Joplin, Mo.	23c. DATE SIGNED 6-2-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-2-52	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope	24d. LOCATION (City, town, or county) (State) Webb City, Missouri
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DATE REC'D BY LOCAL REG. 6-4-52	REGISTRAR'S SIGNATURE [Signature]	55. FUNERAL DIRECTOR'S SIGNATURE Steve Parker Mortuary, Joplin, Mo.	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED 6-9-52

Jasper County Health Office

County File Number 52/6/434

Date Filed 6-9-52

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *E. 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.