

AUG 28 1927

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

23380

1. PLACE OF DEATH  
 County Stoddard Registration District No. 540  
 Township Overton Primary Registration District No. 6102  
 City Jefferson St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Jesse James  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elsie May James

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 26 1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
41 9 3

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29 1927

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1927, to July 29, 1927, that I last saw him alive on July 29, 1927, and that death occurred, on the date stated above, at 7:45 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Myocardial Infarction  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 19 da.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Ark

10. NAME OF FATHER John James

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Ann Hillman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Puxie (STATE OR COUNTRY) Mo

14. INFORMANT Mrs Hilda Heston (Address) Jefferson

15. FILE July 29 1927 C. L. Hope REGISTRAR

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH. \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH. \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY. \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS. \_\_\_\_\_  
 (Signed) C. A. Edman, M. D.  
 (Address) Puxie Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Overton Cemetery DATE OF BURIAL July 30 1927

20. UNDERTAKER Heston-White-Stoddard ADDRESS Puxie Mo

R. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1950

GR should be made

of the situation and be carefully supervised

2

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County Stoddard Registration District No. 876 File No. \_\_\_\_\_  
 Township Over beer Primary Registration District No. 0102 Registered No. 76  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Jesse James  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 26-1885

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>41</u>	<u>9</u>	<u>3</u>		

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29 1927

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, (that I last saw h. \_\_\_\_\_ since on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_, Mo.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH? \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

15. St Hope 12.27 1927  
 REGISTER

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_  
 19\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

should be careful. AGE should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important. REG STRAPS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-23380