

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

Do not use this space.

OCT 4 1927

26252

1. PLACE OF DEATH

County Madison Registration District No. 437 File No. _____
 Township Franklin Primary Registration District No. 6099 Registered No. _____
 City St. Louis (No. _____) St. _____ Ward _____

2. FULL NAME

Della James
 (a) Residence No. 1108 St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 7 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX W. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) March-10-1924
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 2 5 20
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Infant
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Madison, Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER J.W. James
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ill.
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Marie Howell
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

14. INFORMANT J.W. James
 (Address) 1108

15. FILED Aug 19 1927 A. Davis
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 27 1927
 17. I HEREBY CERTIFY, That I attended Deceased from Aug 27, 1927, to Aug 27, 1927 that I last saw her alive on Aug 20, 1927 and that death occurred, on the date stated above, at 3 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Atrophy of thyroid gland, 12.5 B
101
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Intero-renal
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? NO DATE OF _____
 WAS THERE AN AUTOPSY? NO
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) A. Davis, M. D.
 , 19 (Address) Bloomfield

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Clare Cemetery DATE OF BURIAL 8/28 1927
 20. UNDERTAKER J. A. Chiles ADDRESS Bloomfield

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

THE NATIONAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

MEMORANDUM FOR THE DIRECTOR
SUBJECT: [REDACTED]

**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
Township Castor
City Castor (No.)

Registration District No. 837
Primary Registration District No. 6099

File No.
Registered No.
St. Ward)

2. FULL NAME

Della 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 10-1924

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
3 5- 17 *

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)

14.

INFORMANT
(Address)

15.

FILED Aug 19 19 27 S.S. Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 27 19 27

17. I HEREBY CERTIFY That I attended deceased from to 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

N. B. CAUSE OF DEATH may be properly classified. Exact statement may be required by LAW REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AND PRESCRIBED BY LAW

SUPPLEMENTARY

S-26252

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