JAN 19 1928

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

Do not use this space.

37374

1. PLACE OF DEATH

County: Laclede — Registration District No.: 448 — File No.:

Township: Union — Primary Registration District No.: 5688 — Registered No.:

City: (No. ..... St. ..... Ward)

2. FULL NAME: John F. James

(a) Residence. No. ..... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)

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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Lillie F. Allen

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug. 30

7. AGE: Years 64 — Months 3 — Days 28 — If LESS than 1 day, ... hrs. or ..... min.

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:

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Laclede Co.

PARENTS

10. NAME OF FATHER: W. R. James

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): N.C.

12. MAIDEN NAME OF MOTHER: Kathryn Ashenas

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Not Known

14. INFORMANT: Mrs. J. F. James
(Address): Lebanon Mo.

15. FILED: Jan 10, 1928 — N. B. Clinton, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12/28 1927

17. I HEREBY CERTIFY, That I attended deceased from 12-5-, 1927, to 12-28, 1927, that I last saw h[illegible] alive on 12-25-, 1927, and that death occurred, on the date stated above, at 11:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Intestinal
Nephritis
121
92
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Mitral regurgitation
(duration) ..... yrs. ..... mos. ..... ds.

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? Chemical & Microscopic

(Signed) T. H. Casey, M.D.

, 19 (Address) Lebanon 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: Mt. Zion — DATE OF BURIAL: 12/30 1927

20. UNDERTAKER: Palmer — ADDRESS: Lebanon Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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: Laclede — Registration District No.: 448 — File No.:

Township: Union — Primary Registration District No.: 3-608 — Registered No.:

City: (No. ..... St. ..... Ward)

2. FULL NAME: John F James

(a) Residence. No. ..... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 30 X 1863 X

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
64	3	28	

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)

PARENTS

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. X FILED Jan 10 1928 N. B. Clinton X
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12 - 28 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., 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:

(duration) ..... yrs. ..... mos. ..... ds.

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-37374