

N. 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.

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

Do not use this space.
34421 55

1. PLACE OF DEATH
 County Pike Registration District No. 678 File No. _____
 Township St. James Primary Registration District No. 4404 Registered No. _____
 City St. James (No. _____) St. _____ Ward _____

2. FULL NAME William H 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 1, 1922
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
6 1 2

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) St. James (STATE OR COUNTRY) Mo.
 10. NAME OF FATHER Wm R James
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Marion Co Mo.
 12. MAIDEN NAME OF MOTHER Ida Barnes
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Marion Co Mo.

14. INFORMANT Mrs Ida James (Address) St. James Mo
 15. FILED Oct 9 1928 Henry P. Walter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 3 1928
 17. I HEREBY CERTIFY That I attended deceased from April 1928 to Oct 3 1928 that I last saw him alive on Oct 3 1928, and that death occurred, on the date stated above, at 9:05 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart
Mitral Insufficiency
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) POA (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 _____
 (Signed) W. H. Taylor M. D.
10/4, 1928 (Address) St James Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Masonic Cemetery Oct. 4 1928
 20. UNDERTAKER ADDRESS
James and Dowry St. James Mo

