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

Do not use this space.

2796

1. PLACE OF DEATH
County: Ozark — Registration District No.: 645
Township: Bridges — Primary Registration District No.: 5-854
City: ..... (No. ..... St. ..... Ward)

File No.: ..... Registered No.: 3[illegible]

2. FULL NAME: Calista M. 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.

MAR 25 1929

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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov. 18, 1843

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	85	2	0	

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

9. BIRTHPLACE (CITY OR TOWN): Wellington
(STATE OR COUNTRY): Ohio

PARENTS
10. NAME OF FATHER: Freeman Green
11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Ohio
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): unknown

14. INFORMANT: Mrs. Clara White
(Address): Gainesville, Mo.

15. FILED Feb. 11, 1929 Helen M. Ebrite, Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan. 18, 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1929, to Jan. 18, 1929 that I last saw h..... alive on ....., 19..., and that death occurred, on the date stated above, at Jan. 12 11 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
42 h (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) H. O. Pace, M. D.
, 19 (Address) Gainesville 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	DATE OF BURIAL
Lilly Ridge cemetery	Jan. 18 1929
20. UNDERTAKER	**ADDRESS**
Parker + Wood	Gainesville Mo.