

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

Do not use this space.

Rames
22024

JUL 26 1929

1. PLACE OF DEATH

County *Marion*
Township *Marion*
City *Marion*

Registration District No. *533*
Primary Registration District No. *3027*

File No. _____
Registered No. *54*
St. _____ Ward _____

2. FULL NAME

James Stokes

(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) *Widower*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mary Stokes (Dec)*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 17 - 1850*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 2 1

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)

Kentucky

10. NAME OF FATHER

Joe Stokes

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

Kentucky

12. MAIDEN NAME OF MOTHER

Don't know

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

Don't know

14. INFORMANT (Address)

*Wm Stokes
Brynumville, Mo*

15. FILED

30. 1929 Mrs Luke Funkler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 18 1929*

17. I HEREBY CERTIFY, That I attended deceased from _____, 1929, to *June 18*, 1929, that I last saw him alive on *June 18*, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Arteriosclerosis
131
132B (duration) _____ yrs. _____ mos. _____ ds.
Chronic nephritis (duration) *10* yrs. _____ mos. _____ ds.*

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. M. Rames*, M. D.
June 19 1929 (Address) *Marion 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

Hebron Cem. June 20 1929

20. UNDERTAKER

Albert Skinner Marion Mo

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.

CURRENT RECORD

61
8
4

1
2

31

