

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

Do not use this space.

9320

1. PLACE OF DEATH

City Dade Registration District No. 238
 Township Larkwood Primary Registration District No. 4145
 City Larkwood mo (No. _____) St. _____ Ward _____

2. FULL NAME James 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) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-16-31

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, 3 hrs. or _____ min.

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) Larkwood mo
 (STATE OR COUNTRY) Dade Co

10. NAME OF FATHER Philip H. James

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kansas City, Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Elvir Effie

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Garden City, Mo
 (STATE OR COUNTRY) Dade Co mo

14. INFORMANT J. H. James, md
 (Address) Larkwood mo

15. FILED 3-26-31 J. H. James REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-16-1931

17. I HEREBY CERTIFY, That I attended deceased from 3-16-1931, to 3-16-1931, and that I last saw him alive on 3-16-1931, and that death occurred, on the date stated above, at 8:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Immature Infant - 6-7 mo.
Placenta Previa - Cause for
Immature Labor - Lived 2 hrs.
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 159
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED above
 IF NOT AT PLACE OF DEATH.

19. WAS THERE AN OPERATION, PRECEDE DEATH? no DATE OF _____

20. WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) Theodore Allen James, M. D.
 , 19 _____ (Address) Larkwood 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 Garden City 960 DATE OF BURIAL March 17 1931

20. UNDERTAKER B. L. Hauschild ADDRESS Larkwood mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

APR 21 1931

