

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

Do not use this space.

18655

File No. _____
Registered No. 149
St. _____ Ward _____

1. PLACE OF DEATH

County Macon Registration District No. 577
Township Macon Primary Registration District No. 30799
City Hannibal (No. Leveing Hospital)

2. FULL NAME

John L. James
(a) Residence, No. _____ St., _____ Ward, Florida Mo.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 57 yrs. 9 mos. 2 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 Grocia James

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-6-1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
57 9 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farming!
(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) Macon Co. Mo.

PARENTS

10. NAME OF FATHER John James

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

12. MAIDEN NAME OF MOTHER Jane Groce

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

14.

INFORMANT Dr. Elder
(Address) Leveing Hospital

15.

FILED 5/12 1931 O. Clousias
REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 8 - 1931

17. I HEREBY CERTIFY, That I attended deceased from 3-8, 1931, to 5-8, 1931 that I last saw him alive on 5-8, 1931, and that death occurred, on the date stated above, at 3:35:10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Respiratory Failure

CONTRIBUTORY (SECONDARY) Gall bladder operation (duration) _____ yrs. _____ mos. _____ ds.
Acute cholecystitis (duration) _____ yrs. _____ mos. 2 ds.

18. WHERE WAS DISEASE CONTRASTED?

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 5-8-31

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Cholecystitis

(Signed) [Signature]

, 19 _____ (Address) Hannibal

*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

Perry Mo.

May 9 1931

20. UNDERTAKER

ADDRESS

Schwartz Funeral Home Hannibal 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.

JUN 27 1931

