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

Do not use this space.

40133

JAN 20 1932

1. PLACE OF DEATH

County *Boone* — Registration District No. *72* — File No. ....

Township *Centralia* — Primary Registration District No. *4041* — Registered No. *29*

City *Centralia* (No. ...... St. ...... Ward)

2. FULL NAME *James Jasper Angell*

(a) Residence, No. .... St., ... Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If nonresident, give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	*White*	*Married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 17-1855*

7. AGE — YEARS *76* — MONTHS *6* — DAYS *12* — IF LESS than 1 day, ...hrs. or ......min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....

10. Date deceased last worked at this occupation (month and year) ....

11. Total time (years) spent in this occupation ....

FATHER

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Randolph Co., Mo.*

13. NAME *Robert Angell*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky*

MOTHER

15. MAIDEN NAME *Shirley*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky*

17. INFORMANT *Robert L. Angell*
(ADDRESS) *Centralia, Mo.*

18. BURIAL, CREMATION, OR REMOVAL *Centralia, Mo. Cem* DATE *1/1/32*

19. UNDERTAKER *M. M. McDonald*
(ADDRESS) *Centralia, Mo.*

20. FILED *12/31* 193*1* *J. T. Hickerson* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 29th* 19*31*

22. I HEREBY CERTIFY, That I attended deceased from *Dec 29* 19*31* to *Dec 29* 19*31*

I last saw him alive on *Dec 29* 19*31.* Death is said to have occurred on the date stated above, at *10* *P.* m.

The principal cause of death and related causes of importance were as follows:

Bronchial Asthma — Date of onset *About 1920*

Other contributory causes of importance: ....

Name of operation .... Date of ....

What test confirmed diagnosis? .... Was there an autopsy? ....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? .... Date of injury ......, 19......

Where did injury occur? ....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. ....

Manner of injury ....

Nature of injury ....

24. Was disease or injury in any way related to occupation of deceased? ....

If so, specify ....

(Signed) *J. P. Turner* M. D.

(Address) *Centralia, Mo.*