FEB 9

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

2261
Do not use this space.

1. PLACE OF DEATH
(a) County Gentry
(b) Township Cooper
(c) City Darlington
(d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 310
Primary Registration District No. 5429A
Registered No. 138

2. PRINT FULL NAME James Madison Consolver
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 5, 1842

7. AGE: Years 96 | Months 7 | Days 25 | If LESS than 1 day, ... hrs. or 25 min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Morgan County
(STATE OR COUNTRY) Ohio

FATHER
13. NAME William Consolver
14. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Virginia

MOTHER
15. MAIDEN NAME Jane Saunders
16. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Virginia

17. INFORMANT Dan Consolver
(ADDRESS) Darlington Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Hugginsville DATE Feb. 1 1939

19. FUNERAL DIRECTOR Brooks Funeral Home
(ADDRESS) Albany, Mo.

20. FILED Jan 5 1939 Mattie Leonard
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 30 1939

22. I HEREBY CERTIFY, That I attended deceased from November 17, 1938, to Jan. 30 1939
I last saw him alive on Jan. 29, 1939. Death is said to have occurred on the date stated above, at 7:15 A. M.
The principal cause of death and related causes of importance were as follows:

Date of onset

Bronchial Pneumonia

Other contributory causes of importance:

Fractured Hip

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) D. E. Blackstock, M. D.
(Address) King City Mo

(Licensed Embalmer's Statement on Reverse Side)

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 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imp

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1945

STATEMENT BY LICENSED EMBALMER

I, Clifford Brooks, Licensed Embalmer No. 3329

hereby certify that the body recorded on the reverse side of this certificate was not embalmed by me, Thru his signat

no embalming L. E.

No. ..... or by ....., Registered Apprentice No. .....

working under my personal supervision.

Signed Clifford Brooks

Licensed Embalmer No. 3329

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

2261
Do not use this space.

1. PLACE OF DEATH
(a) County: Gentry
(b) Township: Cowgill
(c) City:
Registration District No.: 310
Primary Registration District No.: 3429 A
Registered No.: 138
(d) Street No.: St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME: James Madison Conedver
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Wid

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

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
96	7	25	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1 - 30 , 1939

22. I HEREBY CERTIFY, That I attended deceased from 19 to , 19
I last saw h alive on , 19 Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchial Pneumonia	
Other contributory causes of importance: Fractured hip	

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 Nov. 17, 1938
Where did injury occur? Darlington Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Home
Manner of injury Fall.
Nature of injury Fractured Hip

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) D. E. Blaylock, M. D.
(Address) King City Mo.

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-2261