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.

1 X14028

REC'D APR 25 1939

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

9832
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson — Registration District No. 399

(b) Township Kaw — Primary Registration District No. 1002 — Registered No. 53

(c) City Kansas City, Mo. — (d) Street No. St. Joseph Hospital 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 6611 James Alva Shour

(a) Residence, No. 4416 Norledge 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): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): April 16, 1939

7. AGE: YEARS 0 — MONTHS 0 — DAYS 0 — If LESS than 1 day, 0 hrs. or 0 min.

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): Kansas City, Mo.

FATHER
13. NAME: Herbert M. Shour
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

MOTHER
15. MAIDEN NAME: Hazel Hopkins,
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

17. INFORMANT (ADDRESS): Herbert M. Shour, 4416 Norledge, K.C.Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Moriah Cem. DATE Apr. 18, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): C.H.Blackman & Son, Inc. 2825 Indep. Blvd. K.C.Mo.

20. FILED 4/17 1939 M. M.
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): April 16, 1939

22. I HEREBY CERTIFY, That I attended deceased from Apr 16, 1939 to , 19
I last saw him alive on Stillborn, 19 Death is said to have occurred on the date stated above, at 7:15 m. PM
The principal cause of death and related causes of importance were as follows:

Date of onset

Stillborn from delivery Umb. Cord around neck 4 times & around left arm one time, stopping circulation with descent of head

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? No

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) Dan S. Rising, M. D.
(Address) 1107 Bryant Bldg

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.