

1930 JUN 8 1930

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

17758
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Mo. Registration District No. 399
 (b) Township N. C. Kan Primary Registration District No. 1002
 (c) City N. C. Mo. (d) Street No. Research Hosp 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.

Registered No. **2160**

2. PRINT FULL NAME H. B. James Henry Fletcher

(a) Residence, No. no record St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) no record
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
43 ?

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. no record
 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) no record

FATHER 13. NAME unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER 15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Research Hosp. N. C. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Hill DATE 5/25 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Zwick & Toland
Springfield, Mo.

20. FILED May 24, 1939 M. A. Crow
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-16-39, 19

22. I HEREBY CERTIFY that I attended deceased from _____, 19

I last saw him on 12-11-39. Death is said to have occurred on the date stated above, at 12:00 P.M.
 The principal cause of death and related causes of importance were as follows:

Auto traumatism
Fracture of the skull

Other contributory causes of importance: 210 lbs

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

23. If death was due to external cause (violence), fill in also the following:
 Accident, suicide, or homicide? Accident Date of injury 4-11-39
 Where did injury occur? 70 N. C. Mo.
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Changes in auto window
 Nature of injury in glazing

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) O. G. H. H. H. H. M. D.
 (Address) San Diego, A. C. 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.

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.