

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

**32004**  
Do not use this space.

REC'D OCT 12 1939

**1. PLACE OF DEATH**

(a) County Caldwell Co. 2 Registration District No. 101  
 (b) Township Murble Primary Registration District No. 5149 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (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 Henry Cross

(a) Residence, No. \_\_\_\_\_ 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 (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Berith Cross  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 17, 1849  
 7. AGE YEARS 90 MONTHS 3 DAYS 12 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 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) Caldwell Co. Mo.

FATHER 13. NAME Wm Cross

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

MOTHER 15. MAIDEN NAME Fannie Johnson

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

17. INFORMANT Mrs J B Sloan (ADDRESS) Caldwell Co.

18. BURIAL, CREMATION, OR REMOVAL PLACE Murble Mo. DATE June 30, 1939

19. FUNERAL DIRECTOR (NAME) J W Paland (ADDRESS) Chineer

20. FILED Aug 4 1939 Mrs Ora Sloan Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 29, 1939

I HEREBY CERTIFY That I attended deceased from June 29, 1939 to June 29, 1939  
 I last saw him alive on June 29, 1939 Death is said

to have occurred on the date stated above, at 10:30 am.  
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage  
Apoplexy  
 Date of onset June 29, 1939

Other contributory causes of importance: HTA

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? None 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? NO  
 If so, specify \_\_\_\_\_

(Signed) A. O. Gilliland M. D.  
 (Address) Cameron, 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,

*Arthur H. Doalen*

, or by

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

Signed

*Arthur H. Doalen*

Licensed Embalmer No. 4032

P. O. Address Cameron, Mo

**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.**