

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42366

JAN 13 1940
Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4775

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Seeds Station
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Kansas City J. B. Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 wks
(Specify whether
In this community 50 years
years, months or days)

3. (a) PRINT
FULL NAME

Belle James-520

3. (b) If veteran,
name war no

3. (c) Social Security
No. no

4. Sex Female

5. Color or
race Caucasian

6. (a) Single, widowed, married,
divorced Widowed

6. (b) Name of husband or wife ✓

6. (c) Age of husband or wife if
alive ✓ years

7. Birth date of deceased July 31 1860
(Month) (Day) (Year)

8. AGE:

Years 79 Months 4 Days 15
If less than one day
hr. min.

9. Birthplace Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name John Jones
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Jones
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature K. C. J. B. Hosp
(b) Address Seeds Station

17. (a) Burial (b) Date thereof 12-17-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Stone-McClure

(b) Address Kansas City, Mo.

19. (a) Dec. 17, 1939 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2914 Woodland
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16 in
year 1939 hour 6 minute 40 P. M.

21. I hereby certify that I attended the deceased from Oct 30
1939, to Dec 16, 1939;
that I last saw him alive on Dec 16, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary tuberculosis

Duration

Due to 20

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) (e) Means of injury
23. Signature W. G. Gueden (M.D. or other)
Address Kansas City, Mo. Date signed 12-16-39

JUL 30 1946

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

E M D Land

Licensed Embalmer No. *1848*

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

42366

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson

Registration District No. 399

(b) Township K.C. mo

Primary Registration District No. 1002

(c) City K.C. mo

(d) Street No. _____ St.

(e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number)

(f) How long in U. S., if of foreign birth? _____ yrs. mos. ds.

2. PRINT FULL NAME Selle James

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED was

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

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

7. AGE YEARS 79 MONTHS 4 DAYS 15 If LESS than 1 day, _____ hrs. or _____ 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)

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 Dec 17 39 M. M. Brome
Local Registrar.

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

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw him _____ 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 _____

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) W. H. Buckingham M. D.

(Address) K.C.

