

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

JAN 15 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43914

State File No. _____

Registration District No. 545

Primary Registration District No. 6

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Laclede
(c) Name of hospital or institution: ✓
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Albert Herbert James 520

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Black 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Georgia James 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased July 4, 1877
(Month) (Day) (Year)

8. AGE: Years 62 Months 7 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Linn Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Day laborer

11. Industry or business _____

12. Name Alfred James

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Julia Collins

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Georgia James

(b) Address Laclede, Mo.

17. (a) Burial (b) Date thereof 12/21/1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laclede, Mo.

18. (a) Signature of funeral director W. H. Thorne

(b) Address Laclede, Mo.

19. (a) Dec 21 - 1939 (b) See O. Plowman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Sumner (b) County 1
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29
year 1939 hour 12 minute 30 M.

21. I hereby certify that I attended the deceased from 1935
_____, 19____, to Dec 19, 1939;
that I last saw him alive on Dec 19, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Due to essential hypertension 1936

Due to inguinal hernia

Other conditions (Include pregnancy within 3 months of death) 820

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature W. H. Thorne (M. D. or other) DO

Address Laclede, Mo. Date signed 12/20/39

RECEIVED
District Health Officer No. 11,
District File Number 140-1868
Date Filed JAN-11-1940

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 Me

W.G. Thorne

, Registered Apprentice No. 2876

working under my personal supervision:

Signed W.G. Thorne -

W.G. Thorne

Licensed Embalmer No. 2876

P. O. Address Laclede, 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.