

Registration District No. 15-6-1026

Primary Registration District No. 5-10-2A-4560

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Rollinger
(b) City or town Glenallen Mo.
(If outside city or town limits, write "RURAL" and name of township)
(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 2
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Helen Maylena James.

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced

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

7. Birth date of deceased Oct 22 1938
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>3</u>	<u>3</u>	hr. min.

9. Birthplace Pol Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation BY LICENSED EMBALMER

11. Industry or business

12. Name Edna

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

14. Maiden name Measler

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

16. (a) Informant's own signature Loyce L James
(b) Address Glenallen Mo.

17. (a) Burial (b) Date thereof Jan 26 40
(Month) (Day) (Year)

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

(b) Address Lutesville Mo.

19. (a) Jan 26 1940 (b) W. H. Danforth
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25
year 1940 hour 4.45 minute ? M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Diphtheria

Due to _____

Due to _____

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? _____

I hereby certify that the body whose name is _____ of operations _____
Of autopsy _____
_____ under my personal supervision.

PHYSICIAN
Underline the cause to which death should be charged statistically.

Note: The district health officer shall be signed by the licensed embalmers for removal of the body from the place of death. (e) Means of injury _____
Address Lutesville Mo. Date signed 1-25-40

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.