

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1912

Registration District No. 125

Primary Registration District No. 2009

Registrar's No. 24

1. PLACE OF DEATH:

(a) County CAPE GIRARDEAU
(b) City or town CAPE GIRARDEAU
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: S. E. MISSOURI HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) LIFE

3. (a) PRINT FULL NAME JAMES ALPHONSO LACEY
3. (b) If veteran, name war _____ 3. (c) Social Security No. 493 05 3713

4. Sex M 5. Color or race BLACK 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Freida Patterson Lacey 6. (c) Age of husband or wife if alive 34 years
7. Birth date of deceased July 16 1904
(Month) (Day) (Year)

8. AGE: Years 35 Months 5 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER

12. Name Alphonso Lacey
13. Birthplace Jackson Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Carrie Brown
15. Birthplace East Ripley - Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Freida Lacey
(b) Address Jackson, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-40
(Month) (Day) (Year)
(c) Place: burial or cremation Russell Heights Cemetery

18. (a) Signature of funeral director M. Corbin Tompkins
(b) Address Jackson, Mo.

19. (a) 1-13-40 (Date received local registrar) (b) J. M. Thompson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13
year 1940 hour 4:00 minute 0 M.
21. I hereby certify that I attended the deceased from 1-3-40, 1940 to 1-13-40, 1940
that I last saw him alive on 1-12-40, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
Due to _____
Due to _____
Other conditions Probable Ibc
(Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Alberdon Estlin (M. D. or other) _____
Address Jackson Date signed 1-13-40

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. *305-1*

P. O. Address. *Jackson Ms*

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.