

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15620

MAY 13 1940

Registration District No. 625

Primary Registration District No. 3031

State File No. _____

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Madison
 (b) City or town Marysville Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Francis Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 hrs.
 (Specify whether

In this community _____
 years, months or days)

8. (a) PRINT FULL NAME Louis James ⁵⁷⁰

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

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

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

7. Birth date of deceased Sept - 8 - 1856
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>6</u>	<u>24</u>	hr. min.

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

10. Usual occupation On Relief - Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name unk
 18. Birthplace unk
 (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name unk
 15. Birthplace unk
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Social Security Dept
 (b) Address Marysville Mo

17. (a) Burial (b) Date thereof 4-9-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Ceme

18. (a) Signature of funeral director Joseph J. James
 (b) Address 957 South Main, Marysville Mo

19. (a) Apr - 8 - 40 (b) Manuel C. Clark
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison
 (c) City or town Marysville
 (If outside city or town limits, write "RURAL")
 (d) Street No. 624-5-2 Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 12 Year 1940
 year _____ hour _____ 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 Acute Bronchitis - Duration _____
Pneumonia

Due to _____

Due to _____ DMW

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? 556
 (Specify type of place) _____ (Means of injury) _____

23. Signature Chas. J. Bee (M. D. or other) _____
 Address Marysville Mo Date signed 4/8/40

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.....

W. Dean Campbell....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
W. Dean Campbell

Licensed Embalmer No. *2670*

P. O. Address. *Manjville, 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.