

Registration District No. **4** Primary Registration District No. **3001**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirkville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
515 W. Hickory
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9**
(Specify whether
In this community **Life time**
years, months or days)

3. (a) PRINT FULL NAME **James Everett Booth** **200**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife 6. (c) Age of husband or wife If alive **9** years (Day) (Year)

7. Birth date of deceased **12** (Month) **1938** (Day) (Year)

8. AGE: Years **1** Months **6** Days **2** If less than one day hr. min.

9. Birthplace **Kirkville** (City, town, or county) **Mo** (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name **James R. Booth**
18. Birthplace **La Clede** (City, town, or county) **Mo** (State or foreign country)

{ 14. Maiden name **Eunice Warner**
16. Birthplace **Queen City** (City, town, or county) **Mo** (State or foreign country)

16. (a) Informant **James R. Booth**

(b) Address **515 W Hickory, Kirkville Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **6 13 40** (Month) (Day) (Year)

(c) Place: burial or cremation **Highland Park**

18. (a) Signature of funeral director **DEC Green**

(b) Address **Kirkville Mo**

19. (a) **6/13/40** (Date received local registrar) (b) **Spencer Freeman** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Adair**
(c) City or town **Kirkville Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **515 West Hickory**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **9** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **June 11** day **1940** year **1940** hour **4** minute **20 P.M.**

21. I hereby certify that I attended the deceased from **May** 19**40**, to **June 11** 19**40** that I last saw him alive on **June 10** 19**40** and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Nephritis Secondary to Malnutrition and Cachexia**

Due to **130**

Other conditions (Include pregnancy within 3 months of death)

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.A. Thomas** (State or other) **300** Address **Kirkville** Date signed **6/13/40**

Duration

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 7-40-1453

Date Filed JUL-15-1940

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.....

Mrs. Laura Riley

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Laura Riley

Licensed Embalmer No. 3907

P. O. Address Kirksville, 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.