

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

FILED SEP 24 1938

Registration District No. 899 Primary Registration District No. 6205 Registrar's No.

1. PLACE OF DEATH:
 (a) County Webster
 (b) City or town Earlsland
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location) 2
 (d) Length of stay: In hospital or institution 2 (Specify whether
 In this community ✓ years, months or days 240

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Webster
 (c) City or town Earlsland, Mo.
 (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.

3. (a) PRINT FULL NAMES James America
 3. (b) If veteran, name war ✓ 3. (c) Social Security No. 240

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 3
 year 1938 hour 10 minute P. M.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Joseph H. Ball 6. (c) Age of husband or wife if alive 96 years
 7. Birth date of deceased Feb. 6 1863
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec. 21 1938
 to Dec. 3 1938
 that I last saw her alive on Dec. 3 1938
 and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 9 Days 7 If less than one day hr. min.

Immediate cause of death Cerebral hemorrhage
 Duration

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

Due to 92%
 Due to

10. Usual occupation Housewife
 11. Industry or business ✓

Other conditions (Include pregnancy within 3 months of death)

MOTHER FATHER { 12. Name James Mason
 13. Birthplace Webster Co. Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Rebecca Jane Ross
 15. Birthplace Webster Co. Mo.
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings:
 Of operations
 Of autopsy
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Leora Ripper
 (b) Address Earlsland, Mo.
 17. (a) Burial (b) Date thereof Dec. 6 1938
 (Burial, cremation, or removal) (Month) (Day) (Year)

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? ✓

18. (a) Signature of funeral director W. Marshall
 (b) Address Marshallfield, Mo.
 19. (a) (Date received local registrar) (b) (Registrar's signature)

82 | ✓
 While at work? ✓ (Specify type of place) (e) Means of injury ✓
 23. Signature A. C. Rossler, M.D. (M. D. or other)
 Address Earlsland, Mo. Date signed 9-12-1938

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, fact should be so stated above.

No. 2B
2-21-40
I X22559

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30034**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **899**

Primary Registration District No. **6205**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Webster
 (b) City or town Jackson T.P.
(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 _____
(Specify whether
 In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (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.

3. (a) PRINT FULL NAME James American McCall
 3. (b) If veteran, name war WWI
 3. (c) Social Security No. _____

20. DATE OF DEATH Month Dec day 3
 year _____ hour _____ minute _____ M.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
 7. Birth date of deceased _____
(Month) (Day) (Year)

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

8. AGE: Years 75 Months 9 Days 7 If less than one day _____ hr. _____ min.

Immediate cause of death _____
 Due to _____
 Due to _____

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) _____
 19. (a) Dec 10 (b) EM Bailey
(Date received local registrar) (Registrar's signature)

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

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY

