

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.

FILED OCT 10 1940

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

31861
 Do not use this space.

1. PLACE OF DEATH

(a) County Kansas 20 Registration District No. 241

(b) Township S. Benton Primary Registration District No. 5334 Registered No. 1271

(c) City Buffalo or (d) Street No. _____ St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James M. Kee

(a) Residence, No. Buffalo, Mo. St.

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-22-1860

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	80	1	36	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as saw mill, bank, etc. Farmer

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. 0

FATHER

13. NAME Unknown 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____ 9

MOTHER

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) Effie Anderson
Buffalo Mo. P. 2

18. BURIAL, CREMATION, OR REMOVAL PLACE Cushing Co. Kan. DATE 9-20 1940*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) S. B. Fox
Buffalo Mo.

20. FILED 10/10 1940 Hannay Moore
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-18, 1940

22. I HEREBY CERTIFY, That I attended deceased from Mo 9-18-, 1940, to 4, 1940

I last saw him alive on 9-18-, 1940 Death is said to have occurred on the date stated above, at 5:45 P.M.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage
arterio Sclerosis

Date of onset 9-18-40
HTC,

Other contributory causes of importance: 131

Chronic parenchymatous
degenerations DK

Name of operation none Date of _____

What test confirmed diagnosis? usual Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 1940
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) E. B. Plummer, M. D.
218 (Address) Buffalo Mo

JUL 3 1941

RECEIVED

District Health Officer No. 7,

Dist. Health Officer No. 7, 10-46-1482

Date Filed 10-11-40

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

Royde Montgomery

Licensed Embalmer No. 3592

P. O. Address

Buffalo, 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.