

240
39
13159

Registration District No. **257**

Primary Registration District No. **3036**

Registrar's No. **198**

1. PLACE OF DEATH:

(a) County **St. Charles**

(b) City or town **St. Charles**

(c) Name of hospital or institution: **St. Joseph Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 wks.** (Specify whether years, months or days)

In this community **3 weeks**

3. (a) PRINT FULL NAME **Silvester L. Jamison**

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 **Widowed**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **48** years (Day) (Year)

7. Birth date of deceased **Oct. 1940**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
7 25 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name **Leland E. Jamison**

13. Birthplace **Roby Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Leta Litter**

15. Birthplace **Don't know Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Leland E. Jamison**

(b) Address **Wentzville Mo.**

17. (a) **Jamestown Mo.** (b) Date thereof **11-21-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Jamestown Mo.**

18. (a) Signature of funeral director **W. J. P. ...**

(b) Address **Wentzville, Mo.**

19. (a) **11/20/40** (b) **Clarence H. Hepler**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Charles**

(c) **St. Charles**
(If outside city or town limits, write "RURAL")

(d) Street No. **0** (If rural, give location)

(e) If foreign born, how long in U. S. A.?

FILED DEC 11 1940

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **20** year **1940** hour minute M.

21. I hereby certify that I attended the deceased from **Nov. 17** 19**40** to **Nov. 20** 19**40** that I last saw him alive on **Nov. 20** 19**40** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardium** Duration **2 wks.**

Due to **158**

Due to

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?

770 (Specify type of place) (e) Means of injury

23. Signature **H. J. Cauty, M.D.** (M. D. or other)

Address **St. Charles Mo.** Date signed **11-20-40**

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

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. *2711*

P. O. Address *Wrightsville, N.C.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.