

13-47  
-3  
X23159

State File No. \_\_\_\_\_

**FILED FEB 18 1941**

Registration District No. 220 Primary Registration District No. 1201 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: Stoddard County

(a) County Stoddard County

(b) City or town "Rural" Richland Twp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Morehouse, Missouri "Rural"  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community Life  
years, months or days

3. (a) PRINT FULL NAME JAMES EDWARD TIMS

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race white

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 13 1941  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

0	0	9	hr. min.
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9. Birthplace Stoddard County, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name Ham P. Tims

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

14. Maiden name Gladys Summers

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

16. (a) Informant Ham P. Tims

(b) Address Morehouse, Mo. "Rural"

17. (a) Burial (b) Date thereof 1/23/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Idalia, Missouri

18. (a) Signature of funeral director [Signature]

(b) Address Sikeston, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard 103

(c) City or town Morehouse, Missouri "Rural"  
(If outside city or town limits, write "RURAL") 0

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 22  
year 1941 hour 8:00 minute 30 PM.

21. I hereby certify that I attended the deceased from Jan 13 1941 to Jan 22 1941  
that I last saw him, alive on Jan 22 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth 1 wk  
Placenta Previa  
of Mother

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 154  
(Include pregnancy within 3 months of death)

Major findings: [Signature]

Of operations \_\_\_\_\_

Of autopsy [Signature]

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) None

(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? \_\_\_\_\_

1511  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) 0

Address Sikeston Date signed 1-31-41

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

Body not embalmed

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Harvey Johnson*

Licensed Embalmer No. 3704

P. O. Address Sikeston, Missouri

**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.**

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21-40  
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FILED MAY 9 1949

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 4610

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 839

Primary Registration District No. 6101

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Richland 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)

3. (a) PRINT FULL NAME James Edward Sims

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

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

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)

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

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

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..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4-2541 (b) J.P. Brandon (Registrar's signature)  
(Date received local registrar)

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.

DECLARATION OF CERTIFICATION

20. DATE OF DEATH: Month Jan day 22  
year 1949 hour..... minute..... M.

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

Immediate cause of death.....  
Due to.....  
Due to.....

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 M. A. Anderson (M. D. or other)

Address Keokuk Mo. Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

**RECEIVED**

**District Health Officer No. 2,**

**District File Number** \_\_\_\_\_

**Date Filed** \_\_\_\_\_