

Registration District No. **546** Primary Registration District No. **5738**

3000  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**  
(a) County **Marion Springs**  
(b) City or town **Vicksy**  
(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** **Grover E James**  
**3. (b) If veteran, name war** **World War** **3. (c) Social Security No.**

**4. Sex** **Male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Single**  
**6. (b) Name of husband or wife** **6. (c) Age of husband or wife if alive** years  
**7. Birth date of deceased** **7-29-1890**  
(Month) (Day) (Year)

**8. AGE:** Years **50** Months **6** Days **24** If less than one day hr. min.

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

**10. Usual occupation** **School teacher**

**11. Industry or business**  
**12. Name** **Robert James**  
**13. Birthplace** **Vicksy Mo**  
(City, town, or county) (State or foreign country)  
**14. Maiden name** **Anna Riche**  
**15. Birthplace** **Mo**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **John Jones**  
**(b) Address** **Vicksy Mo**

**17. (a)** **Burial** **(b) Date thereof** **3-25-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** **Halder Cem**  
**18. (a) Signature of funeral director** **W. H. Schlieder**

**(b) Address** **St James Mo**

**19. (a)** **Feb 27 1941** **(b)** **S. A. Warner**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **Marion 63**  
(c) City or town **Rural - Vicksy 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.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **2** day **23**  
year **1941** hour **9:30** minute **P** 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 **No Accidental!** **In car seat!** **quest.**  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

**PHYSICIAN**  
Major findings: **none**  
Of operations \_\_\_\_\_  
Of autopsy **none**  
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 **Feb 23 - 1941**  
(c) Where did injury occur? **On Highway 68**  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**415** (Specify type of place) **Cor Rick** (e) Means of injury  
**23. Signature** **J. Jones** (M. D. or other) **1**  
Address **Vicksy** Date signed **3/26**

170-C6  
95  
AUG

4 1941

RECORDED IN THE OFFICE OF THE STATE ARCHIVIST

**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 W. E. Licklider

Licensed Embalmer No. 1970

P. O. Address St. James 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 546

Primary Registration District No. 5738

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Spring Creek  
(If outside city or town limits, write "RURAL" and name of township)  
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 Grover E. James

3. (b) If veteran, name war \_\_\_\_\_ (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 \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 50 Months 6 Days 24 If less than one day \_\_\_\_\_ 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) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 23 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Car accident, collision against bridge Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: 1700  
Of operations 21  
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, homicide (specify) Accident  
(b) Date of occurrence Feb 23 - 1941  
(c) Where did injury occur? on highway against bridge (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? on highway against bridge  
While at work? no (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. Jones (M. D. or other) \_\_\_\_\_  
Address Pickering Date signed 2/23/41

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

ROBERT MOORE

SUPPLEMENTARY

AUG 4 1941

STATE OF MICHIGAN DEPARTMENT OF HEALTH

**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.**