

**APR 15 1941 85**

Registration District No. \_\_\_\_\_

Primary Registration District No. **1001**

Registrar's No. **354**

1. PLACE OF DEATH: **BUCHANAN**  
 (a) County: \_\_\_\_\_  
 (b) City or town: **ST. JOSEPH**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **STATE HOSPITAL No. 2**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **11 mo. 29 days**  
(Specify whether)  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME: **WALTER JAMES**  
 (b) If veteran, name war: \_\_\_\_\_  
 (c) Social Security No. **None**

4. Sex: **M**  
 5. Color or race: **Col.**  
 6. (a) Single, widowed, married, divorced: **S. D.**  
 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 **40** Months **?** Days **?**  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation: **Hotel work**

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

MOTHER FATHER  
 { 12. Name: **Walter James**  
 { 13. Birthplace: **Miss.**  
(City, town, or county) (State or foreign country)  
 { 14. Maiden name: \_\_\_\_\_  
 { 15. Birthplace: **not known**  
(City, town, or county) (State or foreign country)

16. (a) Informant: **Hospital Records**  
 (b) Address: **State Hosp. #2, St. Joseph, Mo.**

17. (a) **BURIAL**  
(Burial, cremation, or removal) (b) Date thereof: **4-1-1941**  
(Month) (Day) (Year)

(c) Place: burial or cremation: **Asylum Cemetery**

18. (e) Signature of funeral director: **R. Quinn**

(b) Address: **1602 West Main St.**

19. (a) **April 1-1941**  
(Date received local registrar) (b) \_\_\_\_\_  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State: **Mo.** (b) County: **Jackson**  
 (c) City or town: **Texas City 48**  
(If outside city or town limits, write "RURAL")  
 (d) Street No.: **615 Independence Ave.**  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** Day **27**  
 year **1941** hour **9** minute **00** P. M.

21. I hereby certify that I attended the deceased from **July 1, 1940**, to **March 27, 1941**; that I last saw him alive on **Mar 27, 1941**; and that death occurred on the date and hour stated above.

Immediate cause of death: **Aspiration pneumonia** **2 days**

Due to: **Paralytic seizures**

Due to: **General Paresis - 4 yrs.**  
**Therapeutic Malaria (Quartan)**

Other conditions (include pregnancy within 3 months of death): \_\_\_\_\_

Major findings: \_\_\_\_\_  
 Of operations: **30 B**  
 Of autopsy: \_\_\_\_\_

Duration  
 2 days  
 4 yrs.  
 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? **65**

(e) Means of injury: \_\_\_\_\_  
(Specify type of place)

23. Signature: **Kenneth Thompson** M. D. **307 D.**

Address: **State Hosp #2, St. Joseph, Mo.** Date signed: **8-31-41**

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

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**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.**