DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAY 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13965

Registration District No. 85 | Primary Registration District No. 1001 | Registrar's No. 446

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1019 Logan (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community 3 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan

(c) City or town St. Joseph (If outside city or town limits, write "RURAL")

(d) Street No. 1019 Logan (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME JAMES EDWIN TIMMONS

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife ANNA POPE TIMMONS

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased July (Month) 19th. (Day) 1867 (Year)

8. AGE: Years 73 | Months 9 | Days 2 | If less than one day ___ hr. ___ min.

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

10. Usual occupation Mechanic

11. Industry or business

MOTHER FATHER

12. Name Robert A. Timmons

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

14. Maiden name Unknown

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

16. (a) Informant James C. Timmons Jr.

(b) Address 1019 Logan St. Joseph, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4--22--41 (Month) (Day) (Year)

(c) Place: burial or cremation Birmingham Alabama.

18. (a) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) Apr 22 1941 (Date received local registrar) (b) H J Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21st. year 1941 hour 6 minute 05 A.M.

21. I hereby certify that I attended the deceased from 2-19- 1941, to 4-21 1941 that I last saw him alive on 4-21- 1941 and that death occurred on the date and hour stated above.

Immediate cause of death

Hypertensive Heart disease

~~Due to~~

Rt Paraplegia

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Owen W. Craig (M. D. or other) MD

Address St Joseph Mo Date signed 4-22-41

(Licensed Embalmer's Statement on Reverse Side)

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 me

, Registered Apprentice No.

working under my personal supervision.

Signed Geo E Daniel

Licensed Embalmer No. 3300

P. O. Address St Joseph M

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.

S. No. 2B
00—4-25-41
I X27852

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

PROVENG MOOR

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13965

Registration District No. 85 | Primary Registration District No. 1001 | Registrar's No. 446

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME James Edwin Timmons
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
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 73 Months 9 Days 2 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 21 year 1941 hour minute M.
21. 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.

	Duration
Immediate cause of death Hypertension	
Heart Disease	
~~Dist~~ Paraplegia	
Due to Hypertension	240/120
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Owen D Craig (M. D. ~~another~~)
Address Date signed 6/21/41

SUPPLEMENTARY

S-13965