

MAY 9 1941

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

14151  
Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 130  
(b) Township W. E. M. Hospital Primary Registration District No. 3009 Registered No. 1327  
(c) City W. E. M. Hospital (d) Street No. W. E. M. Hospital St. W. E. M. Hospital  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

JAMES DARNELL MCKENZIE  
(a) Residence, No. Charleston St. Mo (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF NONE 24-1931

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCTOBER 7, 1936

7. AGE YEARS 5 MONTHS 9 DAYS 26 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. AT HOME  
9. Industry or business in which work was done, as saw mill, bank, etc. INFANT  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation ✓

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ELBRIDGE, TENN

FATHER 13. NAME ARTHUR LEE MCKENZIE

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ADAMSVILLE, TENN

MOTHER 15. MAIDEN NAME NELLIE RICE

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ILLINOIS

17. INFORMANT (ADDRESS) ARTHUR LEE MCKENZIE  
ANNISTON, MO

18. BURIAL, CREMATION, OR REMOVAL PLACE CHARLESTON, MO DATE 4-4 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) LAIR NUNNLEE  
CHARLESTON, MO

20. FILED 4-3-41 19 Jan Compass Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 3 1941

22. I HEREBY CERTIFY, That I attended deceased from 3/31 1941, to 4/3 1941

I last saw him alive on 4/3 1941. Death is said to have occurred on the date stated above, at 8:30 a.m.

The principal cause of death and related causes of importance were as follows:

Influenzal Meningitis 3/28/41  
27 1/2  
Other contributory causes of importance: Bilateral suppurative otitis media 3/14/41

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signed) Dr. Cochran M. D.  
(Address) Cape Girardeau, Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imp

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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.....

*J. W. Rister*

Licensed Embalmer No. *3980*

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, above space should be left blank.**