

FILLED OCT 16 1941

Registration District No. 837

Primary Registration District No. 5099

Registrar's No.

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

1. PLACE OF DEATH: *Stoddard*  
 (a) County: *Stoddard*  
 (b) City or town: *North-Central*  
 (c) Name of hospital or institution: *County Home*  
 (d) Length of stay: *2 weeks*

2. USUAL RESIDENCE OF DECEASED:  
 (a) State: *Mo.* (b) County: *Stoddard*  
 (c) City or town: *Bell City*  
 (d) Street No.:  
 (e) If foreign born, how long in U. S. A.?: *0* years.

3. (a) PRENT FULL NAME: *JAMES MONROE WHITE*

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

4. Sex: *Male* 5. Color: *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: *March 9 1865*

8. AGE:	Years	Months	Days	If less than one day
	<i>74</i>	<i>6</i>	<i>8</i>	hr. _____ min.

9. Birthplace: *Don't know*

10. Usual occupation: *Farm labor*

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

12. Name: *Don't know*

13. Birthplace: *Don't know*

14. Maiden name: *Don't know*

15. Birthplace: *Don't know*

16. (a) Informant: *No information*

(b) Address: *Don't know*

17. (a) *Burial* (b) Date thereof: *9/18/41*

(c) Place: burial or cremation: *County Home*

20. DATE OF DEATH: Month *Sept.* day *17* year *1941* hour *7* minute *30 P.* M.

21. I hereby certify that I attended the deceased from *Sept 17 1941* to *Sept 17 1941* and that death occurred on the date and hour stated above.

Immediate cause of death: *Pulmonary Tuberculosis*

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

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

Other conditions: \_\_\_\_\_  
Major findings: *12 P*  
Of operations: \_\_\_\_\_  
Of autopsy: *No*

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) \_\_\_\_\_  
(g) Means of injury: \_\_\_\_\_

23. Signature: *John Wilson* (M. D. certifier)  
Address: *Bloomfield, Mo.* Date signed: *9/18/41*

PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No 2,

District File Number 1041-143

Date Filed 10/14/41

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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.**