

FILED NOV 13 1941

Registration District No. **1102**

Primary Registration District No. **5870**

Registrar's No. **5870**

1. PLACE OF DEATH:

(a) County **Lincoln**
(b) City or town **Brigg City Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Passola Hosp**
(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 **Two weeks**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Lincoln**
(c) City or town **Brigg City R-1** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

James Robert Raper

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **0**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Aug 1 1941**
(Month) (Day) (Year)

8. AGE: Years _____ Months **1** Days **26** If less than one day _____ hr. _____ min.

9. Birthplace **Haleyville Ala**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Ober Raper**
13. Birthplace **Haleyville Ala**
(City, town, or county) (State or foreign country)
14. Maiden name **Agnes Yilding**
15. Birthplace **Haleyville Ala**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ober Raper**
(b) Address **Brigg City R-1**

17. (a) **Interred** (b) Date thereof **9-29-41**
(Burial, cremation, or removal) (Month) (Year)
(c) Place: burial or cremation **Oak Ridge Cem**

18. (a) Signature of funeral director **George H. Wood**
(b) Address **Kennett Mo**

19. (a) **10-24-41** (b) **Mrs P. R. Cole**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **28**
year **1941** hour **12** minute **40 P.M.**
21. I hereby certify that I attended the deceased from **Sept 27**
1941 to **Sept 28** 1941
that I last saw him alive on **Sept 27** 1941
and that death occurred on the date and hour stated above.

Immediate cause of death **Illus Colitis acuti** 3 days
Duration

Due to **Battle Injury**

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **1190**

Of autopsy _____

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) (e) Means of injury **11**

23. Signature **George H. Wood** M. D. or other **Do**
Address **Kennett Mo** Date signed **9-29-41**

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

11-41-3

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.