

DEC 22 1941

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. 155

1. PLACE OF DEATH:

(a) County: Phelps

(b) City or town: Rella sum

(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.

In this community: years, months or days

3. (a) PRINT FULL NAME: James S. Hess

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: Married

6. (b) Name of husband or wife: Ellen Hess

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

7. Birth date of deceased: Sept 19, 1867

8. AGE:

Years	Months	Days	If less than one day
74	1	26	hr. min.

9. Birthplace: St James Mo. 11

(City, town, or county) (State or foreign country)

10. Usual occupation: School Teacher

11. Industry or business

12. Name: Scott Hess

13. Birthplace: Ohio 1

(City, town, or county) (State or foreign country)

14. Maiden name: Rhoda Mitchell

15. Birthplace: Ohio 1

(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Ralph Marcellus

(b) Address: Rella Mo

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof: Nov 17, 1941

(Month) (Day) (Year)

(c) Place: burial or cremation: Adams Cemetery

18. (a) Signature of funeral director: Mrs. Harry M. Coul

(b) Address: Rella Mo

19. (a) Nov. 17, 1941 (Date received local registrar)

(b) Joe F. Ayers (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Phelps 81

(c) City or town: Rella Mo. 2

(d) Street No.: 629. Salem Ave D

(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Nov, day: 15th

year: 1941 hour: Nine minute: 9 M.

21. I hereby certify that I attended the deceased from Nov 14

1941, to Nov 15 - 1941

that I last saw him alive on Nov 16 - 1941

and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion 20hrs

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

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

Other conditions: 940

(Include pregnancy within 3 months of death)

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: William H. Blum

(M. D. or other)

Address: St James Mo Date signed: 11/16/41

Duration

20hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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.....

*R. J. McCaw*

Licensed Embalmer No.....

*3953*

P. O. Address.....

*Rivers*

**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.**