

13-40
17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40894

State File No. _____

JAN 24 1942

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4571

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3243 Thompson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
21 Years (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3243 Thompson
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME JAMES GRANT VILES

3. (b) If veteran, name war No 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 Mary Elizabeth 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased May 16 1869
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Blacksmith

11. Industry or business Shelton Viles

12. Name Unknown

13. Birthplace Unknown
(State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Ida Haden

(b) Address 4717 E. 26th St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-10-41
(Month) (Day) (Year)

(c) Place: burial or cremation Lathrop, Mo.

18. (a) Signature of funeral director C. H. BLACKMAN & SON,
2825 Indep. Blvd., K. C. Mo.

(b) Address 12/9/41 (c) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 8th
year 1941 hour 6 minute 30 A. M.

21. I hereby certify that I attended the deceased from 12-4, 1941, to 12-7, 1941, that I last saw him alive on 12-7, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Sclerosis
Arteriosclerosis
Due to _____
Due to _____

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

Major findings: Of operations _____

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? _____

23. Signature _____ (Specify type of place) _____
While at work? _____ Means of injury _____

23. Signature James H. Gering M. D. or other _____
Address Bryant Bldg. K.C. Date signed 12-8-41

Duration 2 wks.
Yes.
Yes.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 *Dixon J. Keeley*
Licensed Embalmer No. *74225*
P. O. Address *Independence, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.