

FILED MAY 18 1942

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. 71

1. PLACE OF DEATH:

(a) County Excelsior Springs
 (b) City or town Excelsior Springs
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Excelsior Springs Boardman
 (If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution 8 days
 In this community 61 years
 years, months or days Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede
 (c) City or town Laclede - Mo. Rt 130
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? ✓ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME James M. Cue

(b) If veteran, name war none (c) Social Security No. none

4. Sex Male 5. Color of hair White 6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife Mary M. Cue 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased November 18-1856
 (Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 4
 If less than one day hr. _____ min. _____

9. Birthplace Bath Co. Kentucky
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer - Stockman

11. Industry or business _____

12. Name Michael M. Cue

13. Birthplace 4 Ballard
 (City, town, or county) (State or foreign country)

14. Maiden name Jane Stewart

15. Birthplace 1 Ky
 (City, town, or county) (State or foreign country)

16. (a) Informant Charles M. Cue

(b) Address Rt 3 Laclede Mo

17. (a) Burial (b) Date thereof Apr. 23-1942
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodland Park Mo

18. (a) Signature of funeral director Church - Archer

(b) Address Excelsior Springs Mo

19. (a) 4-22-42 (b) Mrs. Sadie Redman
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 22
 year 1942 hour 12 minute 25 AM

21. I hereby certify that I attended the deceased from July 29
 1941 to April 22, 1942
 that I last saw him alive on April 21, 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocardial
Poisoning, Alcohol
Broken Fracturing ribcage
 Due to Lesion

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

Major findings: none made
 Of operations _____
 Of autopsy none made

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

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) H.
 (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 place) _____
 While at work _____ Means of injury _____
 23. Signature John L. Trae (M. D.)
 Address Excelsior Springs Mo

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 6-7-42

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.....

Edgar Archer

Licensed Embalmer No. 3311

P. O. Address.....

Leibuty, Mo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14062

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name township)
(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 _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME James Mc Cur
3. (b) If veteran name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Apr day 12
year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 18
(Month) (Day) (Year)

Duration
hememia poisoning
Chronic Interstitial nephritis

8. AGE: Years 85 Months 5 Days _____ If less than one day _____ min.

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: 131a
Of operations _____
Of autopsy _____

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

10. Usual occupation _____

11. Industry of business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

