

James.
34388

Registration District No. 274240

Primary Registration District No. 4-06-34358

1. PLACE OF DEATH:

(a) County NEW MADRID.
(b) City or town LILLBOURN
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1
(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 Mo (b) County New Madrid
(c) City or town Lillbourn
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 24
year 1942 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 20
1942 to Sept 24, 1942
that I last saw him alive on Sept 24, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death
Broncho-Pneumonia Duration
2 days

Due to _____

Due to _____

Other conditions Colitis 2 wks
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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?

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature E. E. Jones (M. D. or other)
Address Lillbourn Mo Date signed 9-25-42

3. (a) PRINT FULL NAME HUGH B. James.

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife W. James. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 8-16-42
(Month) (Day) (Year)

8. AGE: Years _____ Months 1 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace MO (City, town, or county) 0 (State or foreign country)

10. Usual occupation None

11. Industry or business None

MOTHER FATHER { 12. Name Wm James
13. Birthplace MO
(City, town, or county) (State or foreign country)
14. Maiden name Lillbourn B. Carr.
15. Birthplace MO
(City, town, or county) (State or foreign country)

16. (a) Informant Wm James.
(b) Address Lillbourn MO

17. (a) Buried (b) Date thereof 9-25-42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Home

18. (a) Signature of funeral director G. H. Nelly
(b) Address Lillbourn MO

19. (a) Sept 26-42 (b) Thos. D. L. Parrell
(Date received local registrar) (Registrar's signature)

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

72
0
0

RECEIVED

District Health Office No. 2

District File Number 1042-1314

Date Filed 10-15-42

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.....

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, above space should be left blank.