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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2091

FILED FEB 9 1943

Registration District No. 99 — Primary Registration District No. 5371 — Registrar's No. 76

32 0 0

1. PLACE OF DEATH:

(a) County: DeKalb
(b) City or town: Maysville (Rural) Adams
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: DeKalb
(c) City or town: Maysville (Rural)
(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: 0

3. (a) PRINT FULL NAME: Jacob Willis Flanders
3. (b) If veteran, name war: .....
3. (c) Social Security No. .....

4. Sex: Male
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Anna Flanders
6. (c) Age of husband or wife if alive: 24 years
7. Birth date of deceased: February (Month) 16 (Day) 1909 (Year)

8. AGE: Years 33 | Months 10 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace: DeKalb Co. (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation: Farmer
11. Industry or business: General Farming

MOTHER FATHER
12. Name: James A. Flanders
13. Birthplace: Mo. (City, town, or county) 0 (State or foreign country)
14. Maiden name: Effie Dunaway
15. Birthplace: Mo. (City, town, or county) 0 (State or foreign country)

16. (a) Informant: Kirk Flanders
(b) Address: Maysville Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 8-43 (Month) (Day) (Year)
(c) Place: burial: Shambaugh Cope, Weatherby Mo
18. (a) Signature of funeral director: Pilcher Funeral Home
(b) Address: Maysville Mo
19. (a) 1-8-43 (Date received local registrar) (b) C. M. Wingley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6 year 1943 hour 4:45 minute AM M.
21. I hereby certify that I attended the deceased from Dec 10, 1942 to Jan 6, 1943 that I last saw him alive on Jan 5, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Glomerulo-Nephritis — Duration 5 yrs
Due to: 318
Due to: .....
Other conditions: Arteriosclerosis
(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: 0
23. Signature: W. Harold Foster (M. D. or other) D.O.
Address: Maysville Mo Date signed 1/8/43

1248 (Licensed Embalmer's Statement on Reverse Side)

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

APR 28 1943

JUN 29 1943

JUL 17 1942

JAN 23

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 [signature]

Licensed Embalmer No. 3960

P. O. Address Maysville 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.