

FILED FEB 16 1942

Registration District No. 200

Primary Registration District No. 5729

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Madison  
(b) City or town Madison  
(c) Name of hospital or institution: St. Joseph's Hospital  
(d) Length of stay: In hospital or institution all his life  
In this community all his life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madison  
(c) City or town Madison  
(d) Street No. ....  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME JAMES SUITS

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 9  
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive 9 years  
7. Birth date of deceased 2-11-1862

8. AGE: Years 75 Months 9 Days 26 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business ✓

12. Name J. M. Suits

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

14. Maiden name Clarence

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

16. (a) Informant Edward Suits

(b) Address Clarence Mo.

17. (a) (Burial, cremation, or removal) not given (b) Date thereof 12-10-42

(c) Place: burial or cremation not given

18. (a) Signature of funeral director Ed. Suits

(b) Address Madison Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 7 year 1942 hour 9 minute 2 A. M.

21. I hereby certify that I attended the deceased from 12-7-42 to 12-7-42 that I last saw him alive on 12-7-42 and that death occurred on the date and hour stated above.

Immediate cause of death acute myocardial infarction Duration 8 years

Due to HYPERTENSION (HIGH BLOOD PRESSURE)

Due to 930

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

Major findings: Of operations 930

Of autopsy 930

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ✓

(b) Date of occurrence 12-7-42

(c) Where did injury occur? Clarence Mo.

(d) Did injury occur in or about home, on farm, in industrial place, in public place? on farm

While at work no (Specify type of place) (e) Means of injury ✓

23. Signature Dr. Edward Suits Address Madison Mo Date signed 12/7/42

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

MOTHER FATHER

1037

APR 4 1947

RECEIVED

District Health Officer No. 10

District File Number

12-43-295  
FEB 15 1943

Date Filed

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

*E. E. Hopper*  
Licensed Embalmer No. 4260

P. O. Address *Blaine, Me*

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. 6964

Registration District No. ....

Primary Registration District No. 5729

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Macon  
(b) City or town Redmen  
(If outside city or town limits, write "RURAL" and name of 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 MO (b) County Macon  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. Rural (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James. Suilo-  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day \_\_\_\_\_ Year 1942 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I first saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Feb 11 (Month) 1885 (Day) (Year) \_\_\_\_\_ min.  
8. AGE: 75 Years Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) 3/30/42 (Date received local registrar) (b) Tara B. Hunter (Registrar's signature)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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)  
(b) 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

MOTHER FATHER

SUPPLEMENTARY

