

S. No. 2
4-542
5-17-39
1-1-40

Dr. Rowland
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14584

State File No.

APR 26 1943

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. 217

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

1. PLACE OF DEATH:

(a) County Gascon

(b) City or town Gascon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Free Memorial Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 45 days (Specify whether years, months or days) 3 years

In this community 3 years

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

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 W

6. (b) Name of husband or wife Elizabeth died May 5-1941 6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased aug 29 1854
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

88 7 15 hr. min.

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

10. Usual occupation Lumber business

11. Industry or business retired 10 yrs

12. Name no record

13. Birthplace no record
(City, town, or county) (State or foreign country)

14. Maiden name no record

15. Birthplace no record
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs W. C. Yates

(b) Address 7002 Osburn

17. (a) removal (b) Date thereof 4-14-43
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Thomson Dillon

(b) Address 5th & Wall, Gascon

19. (a) 4-14-43 (b) Dr. Rowland
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gascon

(c) City or town Gascon
(If outside city or town limits, write "RURAL")

(d) Street No. 7002 Osburn
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13th
year 1943 hour 8 minute 35 P. M.

21. I hereby certify that I attended the deceased from July 26 1942 to Apr 13 1943
that I last saw him alive on Apr 13 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis and Myocardial Failure

Due to _____

Due to intercranial fracture of left femur

Other conditions (Include pregnancy within 3 months of death) 1860

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) 1.2.2

(b) Date of occurrence 2-26-43

(c) Where did injury occur? gascon gascon Mo
(City or town) (County) (State)

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

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

23. Signature Dr. Rowland (M. D. or other)

Address Gascon Mo Date signed 4/4/43

1204

43-4-547

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..... *David Dillon*

Licensed Embalmer No. *3898*

P. O. Address..... *Joplin, 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.