

2-43
7-39
X35697

FILED JAN 13 1944

State File No. _____

Registration District No. 200

Primary Registration District No. 5725

Registrar's No. 1245

1. PLACE OF DEATH:

(a) County Macou

(b) City or town Osana Hudson, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Elizabeth Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 147 days 16 hrs
(Specify whether years, months or days)

In this community 147 days 16 hrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County Oklahoma

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

(d) Street No. 300 N. W. 28th
(If rural, give location)

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

If yes, name country 2

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

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married 2 divorced, widowed

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

7. Birth date of deceased Pa. 16. 1862
(Month) (Day) (Year)

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

81 0 2 16 hr. min.

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

10. Usual occupation Catechist

11. Industry or business _____

12. Name Jeremiah Rouse

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

14. Maiden name Milanda Gibson

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

16. (a) Informant Mrs. Glad Wells

(b) Address 2903 N. Robinson, Okla City

17. (a) Burial (b) Date thereof 12-22-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Boys Hill Cemetery

18. (a) Signature of funeral director Albert B. Funkler

(b) Address Missouri Ave

19. (a) 1/4/44 (b) Gora B. Funkler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19 year 1943 hour 4 minute P M.

21. I hereby certify that I attended the deceased from June 22, 1943 to Dec 19, 1943, that I last saw him alive on Pa. 18, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
Chronic suppurative, extensive
nasal
Fractured hip Oct. 22, 1943

Due to _____

Due to _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

Major findings: Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) 1/061

(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 21

23. Signature Frank J. Legend (M. D. or other) D.O.

Address Macou Mo Date signed 12/20 1943

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

MOTHER FATHER

1037

JAN 18 1944

RECEIVED

District Health Officer No. 10

District File Number 1-44-149

Date Filed JAN 12 1944

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 Carland Mason

Licensed Embalmer No. 3414

P. O. Address Mason Ave

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Stell-Medredts Sanitarium
(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)

3. (a) PRINT FULL NAME James M. Rouse
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 _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Dec. 16 (Month) (Day) (Year)

8. AGE: Years 81 Months 2 Days 16 (If less than one day, min.)

9. Birthplace Marion County Mo. (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 _____ (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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) 1/17/44 (Date received local registrar) (b) Jana R. Funkler (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. Year 1943 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death: _____

Branch. Pneumonia
Chronic myocarditis
arterio sclerosis
fractured hip 10-20-43
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) 186 a

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) accident
(b) Date of occurrence Oct. 20, 1943
(c) Where did injury occur? Macon Macon Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Sanatorium
While at work? No. (Specify type of place) (e) Means of injury Fall
23. Signature Frank J. H. [unclear] (M.D. or other) D.O.
Address _____ Date signed 1/17/44

5-42944