

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 16001

FILED MAY 10 1944

Registration District No. 1944

Primary Registration District No. 4519

Registrar's No. 59

1. PLACE OF DEATH:

(a) County TEXAS

(b) City or town CABOOD  
(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 6.3 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County TEXAS 10

(c) City or town CABOOD  
(If outside city or town limits, write "RURAL" 0)

(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 JAMES FREEMAN CURRINGHAM

(b) If veteran, name war \_\_\_\_\_

(c) Social Security No. 496-03-3391

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 29  
year 1944 hour 11 30 minute P.M.

21. I hereby certify that I attended the deceased from Jan 10 1944 to apr 29 1944  
that I last saw him alive on apr 29 1944  
and that death occurred on the date and hour stated above.

4. Sex m Color or race W

5. Color or race W

6. (a) Single, widowed, married, divorced, DIVORCED

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased DEC 19 1880  
(Month) (Day) (Year)

Immediate cause of death: Mitral Insufficiency

Duration 3 yrs

8. AGE: Years 63 Months 4 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Elk Creek Mo 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business LUMBER YARD

12. Name J. M. CURRINGHAM

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

14. Maiden name LOUISA TATE

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

16. (a) Informant Tom Cunningham

(b) Address Cabood Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation CABOOD

18. (a) Signature of funeral director Gaylord V. Elliott

(b) Address Cabood Mo

19. (a) May 1 - 1944 (Date received local registrar) (b) Mrs. Lon Miller (Registrar's signature)

Other conditions: (Include pregnancy within 3 months of death) 92 lb

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? \_\_\_\_\_

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

23. Signature M. Edens (M. D. or other) Address Cabood Mo Date signed May 1 1944

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

RECEIVED

District Health Officer No. 51

District File Number 444281

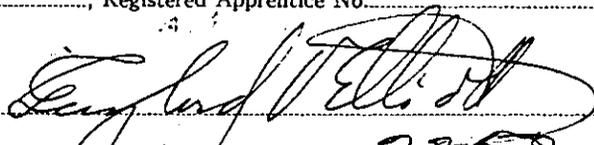
Date Filed 4, 9-44

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. 2252

P. O. Address Cabool 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.