

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17798

FILED JUN 6 1944

State File No. _____

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 75

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

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days
(Specify whether years, months or days)

In this community 21 days

3. (a) PRINT FULL NAME James E. Jeffries

3. (b) If veteran, name war Philippine Insurrection

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Alice Jeffries

6. (c) Age of husband or wife if alive 59 yrs

7. Birth date of deceased Feb. 4, 1883
(Month) (Day) (Year)

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

61 3 4 hr. min.

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

10. Usual occupation Farmer

11. Industry or business Farming

MOTHER FATHER

12. Name John D. Jeffries

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

14. Maiden name Susan E. Price

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

16. (a) Informant Hospital Records, Veterans Administration, Excelsior Springs, Mo.

17. (a) Removal (b) Date thereof 5-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: Appleton City, Mo.
(Burial or cremation)

18. (a) Signature of funeral director HERBERT HOPE

(b) Address Excelsior Springs, Mo.

19. (a) 5-8-44 Mrs. Sadie Redman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates

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

(d) Street No. _____ (If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7
year 1944 hour 10:25 minute A. M.

21. I hereby certify that I attended the deceased from April 17, 1944, to May 7, 1944, that I last saw him in alive on May 7, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, CHRONIC, far advanced, active Duration unknown

Due to _____

Due to _____

Other conditions 1281
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy As shown above

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 Ernest M. Tapp (M. D. or other) MD
Ernest M. Tapp, Major, M.D. Date signed 5-8-44

Address Excelsior Springs, Mo.

1166

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

6-3-44

AUG 23 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 *James A. Mole's*

Licensed Embalmer No. *3296*

P. O. Address *Exclusivo Spg. 7*

--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.