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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21844

FILED JUL 11 1944

State File No. _____

Registration District No. 164

Primary Registration District No. 3032

Registrar's No. 74

51
2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Johnson

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

(c) Name of hospital or institution:
Warrensburg Clinic
(If not in hospital or institution, write street number or location)

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

In this community One Day

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson 51

(c) City or town Warrensburg 2
(If outside city or town limits, write "RURAL")

(d) Street No. Warrensburg Clinic 2
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Edward Houx

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased June 27 1944
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>1</u>	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name James R. Houx

13. Birthplace Johnson Co. Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Doris Lorene Smith

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

16. (a) Informant James R. Houx

(b) Address RFD, Centerview, Mo.

17. (a) Burial (b) Date thereof June 29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Hill

18. (a) Signature of funeral director Sweeney Phillips

(b) Address Warrensburg, Mo.

19. (a) June 29, 1944 (b) Lesla M. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from June 27
19____, to June 28, 19____;
that I last saw him alive on June 28, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 24 hrs

Due to contusion during labor

Due to _____

Other conditions 160C
(Include pregnancy within 3 months of death)

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 R. F. McKinn (M. D. or other) MD
Address Warrensburg, Mo. Date 6-28-44

1601 (Licensed Embalmer's Statement on Reverse Side)

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 Earl Priest

Licensed Embalmer No. 3878

P. O. Address Warrensburg 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.