

1. PLACE OF DEATH: **Saline**

(a) County **Saline**

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

(c) Name of hospital or institution: **no**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **none** (Specify whether)

In this community **80 years** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Saline 97**

(c) City or town **Rural** (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 \_\_\_\_\_

3. (a) PRINT FULL NAME **James Henry Netherton**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**

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

7. Birth date of deceased **October 31 1855**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>88</b>	<b>6</b>	<b>4</b>	hr. _____ min.

9. Birthplace **Davis County Mo. 0**  
(City, town, or county) (State or foreign country)

10. Usual occupation **farmer & carpenter**

11. Industry or business \_\_\_\_\_

12. Name **John Netherton**

13. Birthplace **unknown 9**  
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Jane Jones**

15. Birthplace **unknown 9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Jewel Huff**

(b) Address **R.F.D. Slater, Mo.**

17. (a) **burial** (b) Date thereof **5-7-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fish Creek**

18. (a) Signature of funeral director **Hill Brothers**

(b) Address **Slater, Mo.**

19. (a) **June 10-44** (b) **Mrs. John Giger**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **5th**  
year **1944** hour **12** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **April 27 1944** to **May 5 1944**  
that I last saw him alive on **May 2 1944**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic Nephritis**  
**Chronic cystitis**  
Due to **Chronic Nephritis**  
**Chronic Myocarditis**

Duration
<b>1 wk</b>
?
?
?

Other conditions (Include pregnancy within 6 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? \_\_\_\_\_

23. Signature **O.A. McBurney** (Specify type of blood) \_\_\_\_\_  
Address **Slater, Mo.** (c) Means of injury \_\_\_\_\_  
Date signed **5-6-44**

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

RECEIVED

District Health Officer No. &

District File Number.....

Date Filled: 7-2-44

007151353

**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..... A. C. Hill  
Licensed Embalmer No..... 3090  
P. O. Address..... State 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July  
Registrar's No. 20

Registration District No. 322 Primary Registration District No. (3071)

1. PLACE OF DEATH:  
(a) County Saline  
(b) City or town Rural (Cambridge)  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME James H. Hetherton  
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 Oct 31 (Month) (Day) (Year)

8. AGE: Years 88 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) mo.

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Mrs. John G. G...  
(Date received local registrar) (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 May Day 19 Year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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 \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

22653