DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 13 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31880

Registration District No. 323 Primary Registration District No. 4474 Registrar's No. 21

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Sweet Springs 9 Miles East on 40 Highway
(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 ✓ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 4
(c) City or town Laddonia Mo. 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? Mo (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME FRANK C JAMES
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married 1
6. (b) Name of husband or wife Mrs Fern L. James
6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased April (Month) 3 (Day) 1889 (Year)

8. AGE:	Years	Months	Days	If less than one day
	55	5	3	hr. min.

9. Birthplace Anderson Co. (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Truck man
11. Industry or business Hauling
FATHER
12. Name Quincy James
13. Birthplace Unknown (City, town, or county) 0 (State or foreign country)
MOTHER
14. Maiden name Sarah Beck
15. Birthplace Unknown (City, town, or county) 0 (State or foreign country)
16. (a) Informant Fern LaRue James
(b) Address Laddonia Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17-44 (Month) (Day) (Year)
(c) Place: burial or cremation Laddonia Mo
18. (a) Signature of funeral director Jesse Harvey
(b) Address Sweet Springs Mo
19. (a) Sept 6-44 (Date received local registrar) (b) Mrs Dora Hoffman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 6th year 1944 hour minute 7 A.M.
21. I hereby certify that I attended the deceased from Investigated the death Sept 6. 1944 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Crushed skull.	
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) Accident
(b) Date of occurrence Sept. 6. 1944 097
(c) Where did injury occur? Highway 40 Junction (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? No. 40 Hwy 1½ Miles West of 65 (Specify type of place)
While at work? Yes (e) Means of injury 65 Junction
23. Signature C. L. Lawless Corner Saline Co. (M. D. or other)
Address Marshall Mo. Date signed 9/6-44

1214 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number 1011-44
Date Filed

OCT 26 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 Body not Embalmed, Registered Apprentice No. ..... working under my personal supervision.

Signed Jesse Harvey

Licensed Embalmer No. 2214

P. O. Address Sweet Springs

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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State File No. Oct

Registration District No. 323 Primary Registration District No. Registrar's No. 21

1. PLACE OF DEATH:

(a) County Saline

(b) City or town (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 years, months or days)

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

3. (a) PRINT FULL NAME Frank C James

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 3 (Day) 1882 (Year)

8. AGE: Years 55 Months 5 Days 3 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 26 year 1944 hour minute M.

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

Immediate cause of death crushed skull caused by loss of control of truck & car ran into bank & turned over

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? He was [illegible] rural [illegible] Saline (City or town) (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature C S Sawless, coroner (M. D. or other)

Address Marshall Mo Date signed Sept 26 44

SUPPLEMENTARY

31880