7. S. No. 2
0M—1
ev. 5-17-
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 29 1945

Registration District No. 749

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8827
Registrar's No. 1187

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 6107 Harrison (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: At Home (Specify whether)
In this community 3 years. (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Cass 19
(c) City or town: Freeman (If outside city or town limits, write "RURAL")
(d) Street No. ½ Mile S. of Freeman (If rural, give location)
(e) Citizen of foreign country? No! (Yes or No)
If yes, name country:

3. (a) FULL NAME: James Buchanan Sutton
3. (b) If veteran, name war: None
3. (c) Social Security No. none
4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Deceased unk.
6. (c) Age of husband or wife if alive: ✓ years
7. Birth date of deceased: March (Month) 5 (Day) 1857 (Year)
8. AGE: Years 88 Months 0 Days 7 If less than one day: hr. min.
9. Birthplace: Illinois (City, town, or county) (State or foreign country)
10. Usual occupation: Farmer Retired 30 years
11. Industry or business:
MOTHER FATHER
12. Name: No Record
13. Birthplace: (City, town, or county) No Record (State or foreign country)
14. Maiden name:
15. Birthplace: (City, town, or county) (State or foreign country)
16. (a) Informant: Florence Stout.
(b) Address: 6107 Harrison K.C. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/14/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Freman Cemetery
18. (a) Signature of funeral director: Atkinson & Bro.
(b) Address: Harrisonville Mo
19. (a) 3-13-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12th year 1945 hour 9 00 minute 45 P.M.

21. I hereby certify that I attended the deceased from March 7th, 1945, to March 12th, 1945, that I last saw him alive on March 12th, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Edema of lungs	3 days
Due to: Cerebral Embolus	5 days
Arterio Sclerosis	
Due to:	
Other conditions: Arthritis Deformans (Include pregnancy within 3 months of death)	

Major findings:
Of operations: —
Of autopsy: — 83 lb

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: Dr. Joseph Getelson (M. D. or other) M.D.
Address: 1219 Realty Bldg. Date signed 3-12-45

(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~~ will be embalmed by me, or by Personally

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Floyd Atkinson

Licensed Embalmer No. 3920

P. O. Address Barnesville Ohio

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.