

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 26 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13996

State File No.

Registration District No. 578-3-2N Primary Registration District No. 2-1-5-5783 Registrar's No.

1. PLACE OF DEATH:

(a) County Miller
(b) City or town Rural - Richwoods
(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 60 yrs. years, months or days

3. (a) PRINT FULL NAME AZILEE EMMA JAMES

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Joseph James 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 2 - 1870 (Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation House Keeper

11. Industry or business Farming

12. Name James E. Hughes
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Sarah Duneau
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Alvin James
(b) Address Iberia Mo

17. (a) Burial (b) Date thereof 4-14-45 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Watkins, Mo

18. (a) Signature of funeral director G. E. Casey

(b) Address Iberia Mo

19. (a) April 14-45 (b) Jessie Perkins (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Miller
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Iberia, R# 2 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12 year 1945 hour 9 minute 9 M.

21. I hereby certify that I attended the deceased from April 10 1945, to April 12, 1945;
that I last saw her alive on April 11, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage
Due to arteriosclerosis
Due to _____

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

Major findings: Of operations _____

Of autopsy 830
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? _____

(Specify type of place) _____
While at work? _____ (c) Means of injury _____

23. Signature W. A. Gault (M. D. or other) 2:00
Address Iberia Date signed Mo.

1017

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER, FATHER

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.