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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 21 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14122

Registration District No. 247 — Primary Registration District No. 4366 — Registrar's No. 10

1. PLACE OF DEATH:

(a) County: Newton
(b) City or town: Granby
(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: 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Newton
(c) City or town: Granby (If outside city or town limits, write "RURAL") 1/3
(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 Carey Squires

3. (b) If veteran, name war: No

3. (c) Social Security No: 491-01-2837

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Nell Squires

6. (c) Age of husband or wife if alive: 57 years

7. Birth date of deceased: July (Month) 16 (Day) 1872 (Year)

8. AGE:

Years	Months	Days	If less than one day
72	8	18	hr. min.

9. Birthplace: Clarksburg (City, town, or county) W. Virginia (State or foreign country)

10. Usual occupation: Federal Mining Co.

11. Industry or business: /

FATHER
12. Name: Newton Squires
13. Birthplace: Unknown (City, town, or county) Virginia (State or foreign country)

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

16. (a) Informant: Mrs. Nell Squires
(b) Address: Granby, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 6, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Park Cemetery

18. (a) Signature of funeral director: Knell Mortuary
(b) Address: Carthage, Missouri

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month: Apr. day: 4
year: 1945 hour: 9 minute: 30 a M.

21. I hereby certify that I attended the deceased from: Sept 1, 1944, to: Apr 4, 1945
that I last saw h[illegible] alive on: Apr. 3, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Probable Cancer of liver	2 M.
Due to:	
Due to:	
Other conditions: Cardiac decompensation (Include pregnancy within 3 months of death)	3 Mo.

Major findings:
Of operations: /
Of autopsy: NOK

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? (Specify type of place)
While at work? (e) Means of injury: /

23. Signature: [illegible] (M. D. or other)
Address: Granby Date signed: 4.4.45

1149

(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.

RECEIVED APR 13 1945

District Health Officer No. 12

District File Number 445-53

Date Filed APR 13 1945

Signed Emmett L Sneed

Licensed Embalmer No. 3-91

P. O. Address Carthage

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

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

No. 2B
—5-43
I X36930

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 247 Primary Registration District No. 4366 Registrar's No. 10

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Newton
(b) City or town Granby
(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 James C. Squire
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 July (Month) 16 (Day) 68 (Year)
8. AGE: Years 72 Months 8 Days 18 If less than one day hr. min.
9. Birthplace (City, town, or county) U.S. (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) April 7 45 (Date received local registrar) (b) Lulu Norwood (Registrar's signature)
By Mona Beck

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6 year 1945 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.

	Duration
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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

14122