

FILED APR 28 1945

Registration District No. 299

Primary Registration District No. 6025

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Reynolds

(b) City or town Rural, Black River
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2 miles West of Black
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether

In this community life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Reynolds ⁹⁰

(c) City or town Rural Black River
(If outside city or town limits, write "RURAL")

(d) Street No. 2 miles West of Black
(If rural, give location)

(e) Citizen of foreign country? no ⁰ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME James Henry Elder

3. (b) If veteran, name war no

3. (c) Social Security No. _____

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased November 22 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
76	4	28	hr. _____ min.

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

10. Usual occupation farmer

11. Industry or business _____

12. Name Robert F. Elder

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Sally Lanham

15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Warren Cash

(b) Address Black Missouri

17. (a) burial (b) Date thereof 4-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Black Missouri

18. (a) Signature of funeral director Norman White & Sons

(b) Address Quid White Ironton Mo.

19. (a) April 20 1945 (b) Mrs. Paces Wellington
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1945 hour 2 minute 30 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on April 16, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Pneumonia & Influenza

Due to _____

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? no (Specify type of place) (e) Means of injury _____

23. Signature J. P. Smith (M. D. or other) _____

Address Calinterville, MO Date signed 4/23/45

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

MOTHER FATHER

119K

RECEIVED

District Health Officer No. 5;

District File Number 445226

Date Filed 71 27 45

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.....

was not embalmed

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

working under my personal supervision.

Signed *Amel J. White*

Licensed Embalmer No. *2012*

P. O. Address *Quincy 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. mayRegistration District No. 299Primary Registration District No. 6025

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Rural Block 299
(If outside city or town limits, write "RURAL" and name of town/county)
(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

3. (a) PRINT FULL NAME

James H. Elder

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 s

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

7. Birth date of deceased Nov. 22
(Month) (Day) (Year)8. AGE: Years 76 Months 4 Days 18 If less than one day _____ min.9. Birthplace _____
(City, town, or county) (State or foreign country)

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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 April
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to Pneumonia &Lobar & Bronchial

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____ 108

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 J. R. Pyle M.D. (M. D. or other) _____Address Centerville, Mo. Date signed 5/4/45

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

14411