S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 9 1945

THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 16146

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 129

**1. PLACE OF DEATH:**
(a) County Adair
(b) City or town Community Nursing Home
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Kirksville, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 4 days
years, months or days)

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

3. (a) PRINT FULL NAME JAMES HARVEY EWING
3. (b) If veteran, name war
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov (Month) 11 (Day) 1869 (Year)
8. AGE: Years 75 Months 6 Days 6 If less than one day hr. min.
9. Birthplace Adair Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Allen Ewing
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Sarah Reynolds
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Naomi Scott
(b) Address Kirksville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/45 (Month) (Day) (Year)
(c) Place: burial or cremation Greenton, Mo.
18. (a) Signature of funeral director D E Kelly
(b) Address Kirksville, Mo.
19. (a) 5-23-45 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 17
year 1945 hour 1 minute 2 M.
21. I hereby certify that I attended the deceased from May 13, 1945, to May 17, 1945; that I last saw him alive on May 17, 1945; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Vasomotor collapse | 2 days |
| Due to: Toxemia of Carcinoma of stomach | |
| Due to | |
| Other conditions: Generalized abdominal carcinoma (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy 46 h

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. T. Gutensohn (2 or other) D.O.
Address Kirksville, Mo Date signed 5-19-45

1047

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 6-45-917
Date Filed JUN 7 1945

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 D E E Riley

Licensed Embalmer No. 4181

P. O. Address Kirkville NY

**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.**