

FILED JUN 9 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 5001

Registrar's No. 126

1. PLACE OF DEATH:

(a) County Adair *Clay twp.*
(b) City or town Willmathsville, -RURAL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Willmathsville, Mo. R. No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Kirksville,
(If outside city or town limits, write "RURAL")
(d) Street No. 916 E. McPherson
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6
year 1945 hour 9:30 minute A: M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw her alive on May 5, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia
Due to _____
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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature Rob. Ellis (M. D. or other) _____
Address Kirksville, Mo Date signed 5-10-45

3. (a) PRINT FULL NAME Mollie E. James
3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife William James
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 6 1864
(Month) (Day) (Year)

8. AGE: Years 81 Months 4 Days 0
If less than one day _____ hr. _____ min.

9. Birthplace Adair Co Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Home

11. Industry or business _____
12. Name Elliott Moots
13. Birthplace Unknown _____
(City, town, or county) (State or foreign country)
14. Maiden name Unknown _____
15. Birthplace Unknown _____
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bessie Taylor
(b) Address Willmathsville, Mo.
17. (a) Burial (b) Date thereof 5/8/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Highland Park

18. (a) Signature of funeral director B. E. Riley
(b) Address Kirksville, Mo.
19. (a) 5-23-45 (b) Mrs. J. L. Wagoner
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No. 10

District File Number 6-45-914

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 Dev. Riley

Licensed Embalmer No. 4181

P. O. Address West Knoxville TN

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.