

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

80M-7-20-37

I. X12004

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED SEP 20 1945 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

31203
Do not use this space.

1. PLACE OF DEATH
 (a) County Pike Registration District No. 278
 (b) Township Bozale Primary Registration District No. 3054 Registered No. 12
 (c) City Louisiana (d) Street No. Pike Hospital (If death occurred in Hospital or Institution, write its name instead of street and number) St. 0
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James Atkinson M. Dannold
 (a) Residence, No. Clarksville The St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE-MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 16, 1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>83</u>	<u>5</u>	<u>9</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisiana

FATHER

13. NAME James Atkinson M. Dannold

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Richmond Va.

MOTHER

15. MAIDEN NAME Susan Smith Dillingwater

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.

17. INFORMANT (ADDRESS) John M. Ester

18. BURIAL, CREMATION, OR REMOVAL PLACE Breewood DATE Aug 27, 1945

19. FUNERAL DIRECTOR (ADDRESS) Harry L. Bance

20. FILED 8/27 1945 Clarksville Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 25, 1945

22. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1945, to Aug 25, 1945. I last saw him alive on Aug 25, 1945. Death is said to have occurred on the date stated above, at 10:45 a.m. The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage Date of onset 8/20/45

Other contributory causes of importance:
General arterio-sclerosis Not many

Name of operation (B) Date of

What test confirmed diagnosis? (B) Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury, 19
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify (Signed) E. M. Bartlett M. D.
 (Address) Clarksville, Missouri 8/26/45

11-3

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 9-45-145

Date Filed SEP 17 1945

STATEMENT BY LICENSED EMBALMER

I, Harry Carroll, Licensed Embalmer No. 2439

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Harry Carroll
Licensed Embalmer No. 2439

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.)