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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

By *Ritter or Blylock*

State File No. **33377**

**FILED OCT 24 1945**

Primary Registration District No. **3010**

Registrar's No. **313**

1. PLACE OF DEATH:

(a) County *Cape Girardeau*

(b) City or town *Cape Girardeau Mo*  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution *St. Francis Hospital*  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *5 days*  
(Specify whether years, months or days)

In this community *Life 5 days*  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Cape Girardeau*

(c) City or town *RFD Oak Ridge Mo*  
(If outside city or town limits, write "RURAL")

(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 Marshal DRUM*

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Oct* day *3*  
year *1945* hour *8* minute *40 A.* M.

21. I hereby certify that I attended the deceased from *June*, 1945, to *Oct*, 1945  
that I last saw him alive on *Sept 30*, 1945  
and that death occurred on the date and hour stated above.

4. Sex *M* 5. Color or race *W*

6. (a) Single, widowed, married, divorced *Widowed*

6. (b) Name of husband or wife *Susie Drum* 6. (c) Age of husband or wife if alive: \_\_\_\_\_ years

7. Birth date of deceased: *October 27 1864*  
(Month) (Day) (Year)

Immediate cause of death *Uremic Poison* Duration \_\_\_\_\_

Due to *Prostatic enlarge ment*

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years *80* Months *11* Days *5* If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation *Farmer*

Major findings: Of operations \_\_\_\_\_

Of autopsy *137a*

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

12. Name *Unknown*

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

14. Maiden name *Unknown*

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

16. (a) Informant *J. E. Drum*

(b) Address *Oak Ridge Mo*

17. (a) *Burial* (b) Date thereof *10-4-45*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Oak Ridge Cemetery*

18. (a) Signature of funeral director *Mrs. Corbett Fun. Dir.*

(b) Address *Jackson, Mo.*

19. (a) *10-8-45* (b) *F. W. Phelps*  
(Date received from registrar) (Registrar's signature)

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 *R. D. Blylock* (M. D. or other) *M.D.*

Address *Oak Ridge Mo* Date signed *10-4-45*

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

MOTHER FATHER

District Health Officer No. 4  
District File Number 1045-1219  
Date Filed 10-23-45

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed B. A. Meyer

Licensed Embalmer No. 3051

P. O. Address Jackson 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.**