

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41056**

FILED JAN 14 1946

Registration District No. **4168**

Primary Registration District No. **13**

Registrar's No. **13**

1. PLACE OF DEATH:

(a) County **Dekalb**
(b) City or town **Mayville, Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME

James Bourrett

3. (b) If veteran

name war

3. (c) Social Security

No.

4. Sex **Male**
5. Color or race **white**

6. (a) Single, widowed, married, divorced **1**

6. (b) Name of husband or wife **Anna Bourrett**

6. (c) ~~Age~~ **45** years alive

7. Birth date of deceased **Sept 14 1897**
(Month) (Day) (Year)

8. AGE: Years **67** Months **11** Days **17**
If less than one day hr. min.

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

10. Usual occupation **laborer**

11. Industry or business

12. Name **M. M. Bourrett**
13. Birthplace **Wis.**
(City, town, or county) (State or foreign country)

14. Maiden name **Lillian Lawson**
15. Birthplace **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ann Bourrett**
(b) Address **Mayville Mo**

17. (a) (Burial, cremation, or removal) (b) Date thereof **Sept 2 1946**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mayville Mo**

18. (a) Signature of funeral director **John Bran**

(b) Address **Mayville Mo**

19. (a) **10-24-46** (b) **Rosa Hardman**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Dekalb**
(c) City or town **Mayville Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **0**
(If rural, give location)
(e) Citizen of foreign country? **No**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **11** year **1945** hour **11** minute **0** M.

21. I hereby certify that I attended the deceased from **10** **March**, 19 **45**, to **Sept 2**, 19 **45**;
that I last saw him alive on **Sept 2**, 19 **45**;
and death occurred on the date and hour stated above.
Immediate cause of death **Heart Failure**

Carcinoma of Rectum

Due to

Due to

Other conditions
(Include pregnancy within 5 months of death)

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? (Specify type of place) Means of injury

23. Signature **M. S. Gale** (M. D. or other)

Address **Osborne Mo** Date signed **9/8/46**

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

John S. Bram

Licensed Embalmer No.....

3933

P. O. Address.....

Marionville 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.