

U.S. No. 2
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K37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1487
199
Registrar's No. _____

FILED JAN 31 1946

Registration District No. 147 Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bonley Maternity Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

In this community 3 days

3. (a) PRINT FULL NAME Helene Louise James

3. (b) If veteran, name war none

(c) Social Security No. none

4. Sex Female 5. Color or race white

6. (a) Single, widow, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 6 - 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 7
If less than one day hr. _____ min. _____

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Dr. Francis James

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

14. Maiden name Esther Hoyle

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

16. (a) Informant Dr. F. James

(b) Address Gallatin Mo.

17. (a) Burial (b) Date thereof 1-15-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gallatin Mo.

18. (a) Signature of funeral director Hope Funeral Home
(b) Address Gallatin Mo.

19. (a) 1-13-46 (b) Eralline Adams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess

(c) City or town Gallatin
(If outside city or town limits, write "RURAL")

(d) Street No. none
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 13
year 1946 hour 1 minute 33 P.M.

21. I hereby certify that I attended the deceased from 1/11 1946 to 1/13 1946
that I last saw her alive on 1/13 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure

Due to Premature birth

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

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 Dr. Thompson (M.D. or other) Dr.
Address 619 Garfield Date signed 1/13/46

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

1052

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.....

Was Not Embalmed..... Registered Apprentice No.....
working under my personal supervision.

Signed..... *L. O. Richardson*.....

Licensed Embalmer No. *3302*.....

P. O. Address *Hallatree, 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.