

S. No. 2
M-8-43
5-17-39
P-1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1928
Registrar's No. 96

FILED JAN 25 1948

Registration District No. _____ Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Laughlin Hosp. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days (Specify whether years, months or days)
In this community Kirksville

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clark 23
(c) City or town Rural Sweet Home Twp. 0
(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

Peter F. James

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex M. 0 5. Color or race W. 6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife Mar. Ada Newmaster 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased July 20 1881
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23 year 1945 hour 10 minute P M.

21. I hereby certify that I attended the deceased from Nov 12, 1945, to Nov 23, 1945, that I last saw him alive on Nov 23, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of head & Paucies

Due to _____
Due to _____
Other conditions Obstruction of bile ducts
(Include pregnancy within 3 months of death)

Major findings: Same as above
Of operations _____
Of autopsy 4/69

Duration

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)
(e) Means of injury _____
23. Signature Carl Laughlin, Jr. M.D.
Address Kirkville, Mo. Date signed 12/23/45

8. AGE: Years 64 Months 3 Days 12 If less than one day hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

12. Name John A. James
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Nancy Foster
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mary James
(b) Address Kirkville, Mo.

17. (a) Reinterred (b) Date thereof 11-2-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirkville Cemetery

18. (a) Signature of funeral director Fred Karlen
(b) Address Kirkville, Mo.

19. (a) 12-31-45 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

100013
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 1-46-59

Date Filed JAN 23 1946

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 D. E. Riley

Licensed Embalmer No. 4181

P. O. Address Kentville 40

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.