

FILED AUG 20 1946

Registration District No. 182

Primary Registration District No. 3038

Registrar's No. 86

1. PLACE OF DEATH:

(a) County Linn

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

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

(d) Length of stay: In hospital or institution 45 years (Specify whether years, months or days)

In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME James Joseph White

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Anna M. Dixon

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased: Sept. 1, 1863
(Month) (Day) (Year)

8. AGE: Years Months Days

82	11	12
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If less than one day _____ hr. _____ min.

9. Birthplace Arcola, Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Railroad engineer, ret.

11. Industry or business C. B. & Q. R. R.

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Anna M. White

(b) Address Brookfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-46
(Month) (Day) (Year)

(c) Place: burial or cremation St. Michael Cemetery

18. (a) Signature of funeral director Rusk Funeral Home

(b) Address Brookfield, Mo.

19. (a) 8/14 (Date received local registrar)

(b) W. B. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn

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

(d) Street No. 220 W. North St
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13
year 1946 hour 2 minute 00 P. M.

21. I hereby certify that I attended the deceased from 8-11
_____ 1946, to 8-13 _____ 1946.

that I last saw him alive on 8-13-46 _____ 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral vascular accident

Duration 5 min.

Due to Generalized arteriosclerosis secondary cerebral infarction 2 yrs.

Due to _____

Other conditions _____
(Include pregnancy within 3 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? _____

(Specify type of place)

While at work? _____ (c) Means of injury _____

23. Signature Leopold Bohusack (M. D. or other)

Address Brookfield, Mo. Date signed 8-16

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

18
2

26517

FILED

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 Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, 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.