

No. 2
8-43
5-17-39
1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30932

State File No. _____

FILED OCT 15 1946

Registration District No. _____

Primary Registration District No. 3041

Registrar's No. 106

1. PLACE OF DEATH:

(a) County Macon
(b) City or town macon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ✓
In this community about a week (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 555 1/2 Walnut St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CLAUDE A. James

3. (b) If veteran, name war ✓ 3. (c) Social Security No. 489-12-4043

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced divorced

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

7. Birth date of deceased. 6-3-1879
(Month) (Day) (Year)

8. AGE: Years 67 Months 2 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace macon Mo
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business _____

12. Name William S. James

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

14. Maiden name Lucinda Linsford

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

16. (a) Informant W. James

(b) Address macon Mo

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

(c) Place: burial or cremation Brewer Mo

18. (a) Signature of funeral director Brewer
(b) Address macon Mo

19. (a) Oct 14/46 (b) Smith McNeely
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 6 year 1946 hour 1 minute 30 P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death acute myocarditis

Due to _____

Due to _____

Other conditions 93A
(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 8-6-46

(c) Where did injury occur? macon Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? no (Specify type of place) (e) Means of injury dropped tool

23. Signature A. G. Edwards (M.D. or other) 3
Address Brewer Mo Date signed 8/6/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

29763

185

(Licensed Embalmer's Statement on Reverse Side)

JUN 16 1947

OCT 17 1946

RECEIVED
District Health Officer No. 10
District File Number 10-46-1803
Date Filed OCT 14 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 M. B. Edwards

Licensed Embalmer No. 1961

P. O. Address Beverly 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.