

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4669**
Registrar's No. **38**

Registration District No. **141**

Primary Registration District No. **3025**

1. PLACE OF DEATH:
(a) County **Howell**
(b) City or town **West Plains**
(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 _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Howell**
(c) City or town **West Plains**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **James August McCaffrey**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. **DATE OF DEATH:** Month **2** day **16**
year **1947** hour **12** minute **35** M.

4. Sex **MO** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **1**
6. (b) Name of husband or wife **Offie D. M. Caffrey** 6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **19-1-1882**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **9 Feb 47** to **16 Feb 47**
that I last saw him alive on **15 Feb 47**
and that death occurred on the date and hour stated above.

8. **AGE:** Years **66** Months **9** Days **1**
If less than one day hr. _____ min. _____

Immediate cause of death **Cerebral Hemorrhage**
Hemiplegia - Right
Due to _____
Due to _____

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

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: **83A**
Of operations _____
Of autopsy _____

10. Usual occupation **Carpenter**

11. Industry or business _____

12. Name **unk.**

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

14. Maiden name **unk.**

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

16. (a) Informant **Mrs. J. A. McCaffrey**
(b) Address **West Plains, Mo.**

17. (a) **Burial** (b) Date thereof **1-25-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **pub. furn.**
18. (a) Signature of funeral director **Robertsons**
(b) Address **West Plains, Mo.**
19. (a) **Feb 19-1947** (b) **Beatrice Cook**
(Date received local registrar) (Registrar's signature)

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)
(f) Means of injury _____

23. Signature **Robertson** (M. D. or other) **M.D.**
Address **West Plains, Mo** Date signed **18 Feb 47**

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

379

(Licensed Embalmer's Statement on Reverse Side)

RH Smith

RECEIVED

District Health Officer No. 5,

District File Number

24799

Date Filed

9-28-47

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.....

George R. Drago

....., Registered Apprentice No. *431*

working under my personal supervision.

Signed.....

P. A. Robertson

Licensed Embalmer No. *3435*

P. O. Address.....

West Plains

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.

Registration District No. 141

Primary Registration District No. 3025

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME James A. McCaffrey
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____

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

8. AGE: Years 66 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) Burial (b) Date thereof 1 28 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Beatrice Cook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day _____
Year 1947 Hour _____ minute _____ M.

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

Due to _____

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 _____ (M. D. or other) _____

Date signed _____

SUPPLEMENTARY

MOTHER FATHER

WRITE PLAINLY - USE UNFADING BLACK INK - MARK

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-4669