

No. 2
5-43
5-17-39
I X36671

FILED MAY 7 1947

Registration District No. **1947** Primary Registration District No. **4310**

1. PLACE OF DEATH:

(a) County **Macon**

(b) City or town **Bever**
(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 _____ years, months or days

3. (a) PRINT FULL NAME **SAMUEL F. JAMES**

3. (b) If veteran, name war **3. (c) Social Security** No.

4. Sex **Male** **5. Color or race** **white**

6. (a) Single, widowed, 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. **7-22-1878**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	68	9	8	_____ hr. _____ min.

9. Birthplace. **Wales** **4**
(City, town, or county) (State or foreign country)

10. Usual occupation. **Retired Farmer**

MOTHER FATHER

11. Industry or business

12. Name. **John J. James**

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

14. Maiden name. **Annice James Nees**

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

16. (a) Informant. **Annice James**

(b) Address. **Bever Mo**

17. (a) **Annice** **(b) Date thereof.** **5-3-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. **Bever Mo**

18. (a) Signature of funeral director. **W. J. Edwards**

(b) Address. **Bever Mo**

19. (a) **6-3-47** **(b) Winnie J. Rowland**
(Date received local register) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Macon**

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

(d) Street No. _____ (If rural, give location) **0**

(e) Citizen of foreign country? _____ (Yes or No) **0**

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **24**
year **1947** hour **6** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **Oct. 16**, 19**46**, to **Apr. 29**, 19**47**
that I last saw him alive on **Apr. 29**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of Stomach**
Liver & Gall bladder.

Due to _____

Duration

2-9-0

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

Major findings:
Of operations _____

Of autopsy **H&B**

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? **2**

While at work? _____ (Specify type of place) (2) Means of injury _____

23. Signature. **Dr. F. H. ...** (M. D. or other) **Dr.**

Address **Bever, Mo** Date signed **5/3/47**

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

OCT 20 1952

RECEIVED
District Health Officer No. 10
District File Number 54779
Date Filed MAY - 6 1947

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 *A. G. Edwards*

Licensed Embalmer No. 1961

P. O. Address Bevier 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.