

No. 2
-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14686

State File No. _____
Registrar's No. 11

Registration District No. 296

Primary Registration District No. 6018

1. PLACE OF DEATH:

(a) County RAY
(b) City or town RURAL, FISHING RIVER
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2 1/2 miles South East Ex Spgs
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no, (Specify whether
In this community 11 years
years, months or days)

3. (a) PRINT FULL NAME JAMES A. SEXTON

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mary L. Sexton 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased July 15 1873
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 3 If less than one day hr. min.

9. Birthplace Ray County MO
(City, town, or county) (State or foreign country)

10. Usual occupation Pipe Fitter

11. Industry or business _____

12. Name Lease Sexton 9

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

14. Maiden name Ellen Swaps

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

16. (a) Informant Mrs. Mary L. Sexton

(b) Address R.R. 2 Excelsior Springs Mo.

17. (a) Burial (b) Date thereof 3-20-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Excelsior Springs, Crown Hill Cem.

18. (a) Signature of funeral director Vivian Hope

(b) Address Excelsior Springs, Mo.

19. (a) 3/22/47 (b) Walter D. Baker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County RAY 89
(c) City or town Rural, RR 2 0
(If outside city or town limits, write "RURAL")
(d) Street No. RR 2 Ex Spgs, Mo 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3-18, 1947
day hour minute M.

21. I hereby certify that I attended the deceased from Thursday, 1947 to 3-18, 1947
that I last saw him alive on 3-18, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coronary Thrombosis
Due to Arterio-sclerosis

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

Major findings: act
Of operations _____
Of autopsy _____

Duration
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) (e) Means of injury _____
While at work? _____
23. Signature W. D. Baker (M. D. or other) W.D.
Address Excelsior Springs Date signed 3/19/47

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

also Filed 4-15-47

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 _____
_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed Chas. Virgil Hope

Licensed Embalmer No. 3950

P. O. Address Excelsior Springs

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.