

1. PLACE OF DEATH:

(a) County Ray  
 (b) City or town Lawson, Missouri  
 (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 William 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 Married  
 6. (b) Name of husband or wife Mollie 6. (c) Age of husband or wife if alive 74 years  
 7. Birth date of deceased May (Month) 1869 (Day) (Year)

8. AGE: Years 78 Months 0 Days 13 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 12. Name Abner James  
 13. Birthplace N. Carolina (City, town, or county) (State or foreign country)  
 14. Maiden name Elizabeth Stevens  
 15. Birthplace N. Carolina (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Hattie Russell

(b) Address Lawson, Missouri

17. (a) Burial (b) Date thereof May, 21, 1947 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawson, Cemetery

18. (a) Signature of funeral director Jarman Prichard

(b) Address Lawson, Missouri

19. (a) May, 21, 1947 (b) Mrs. Raymond Neal (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray 89  
 (c) City or town Lawson, Missouri 0  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18  
 year 1947 hour 5 minute 20 P.M.

21. I hereby certify that I attended the deceased from May, 15 - 1947 to May, 18 - 1947  
 that I last saw him alive on May, 18 - 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary occlusion & Cardiac failure Duration 2 hr  
 Due to Chronic Myocardial degeneration with Generalized edema 2 yrs

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?

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature Blair B. Hughes (M. D. or other) \_\_\_\_\_  
 Address Lawson Mo Date signed May 19, 1947

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

7-15-47

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

working under my personal supervision.

Signed

Albert E. White

Licensed Embalmer No. 4168

P. O. Address. Excelsior Springs, 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.