

No. 2
2-45
17-39
X47070

Registration District No. 155

Primary Registration District No. 5579

Registrar's No. 143

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Mineral
(c) Name of hospital or institution: Jasper Co. T.B. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days
(Specify whether

In this community
years, months or days)

3. (a) PRINT FULL NAME James Archie Hiser

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 Single

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

7. Birth date of deceased. Nov 22 1913
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
33 9 14 hr. min.

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

10. Usual occupation Rail Road Employee

11. Industry or business.....

12. Name David Hiser

13. Birthplace No record

14. Maiden name Maria W. H.

15. Birthplace No record

16. (a) Informant Hospital Records

(b) Address Webb City Mo.

17. (a) Burial (b) Date thereof Sept 8 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crescent Hill Cem.

18. (a) Signature of funeral director Carroll Bros.

(b) Address Webb City Mo.

19. (a) SEPT. 12 8:47 (b) J. E. Deery
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Coal 19
(c) City or town Archie 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 6
year 1947 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 2 1947 to Sept 6 1947
that I last saw him alive on Sept 6 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Tubercular Meningitis

Due to Tuberculosis of the 9th 10th 11th & Thoracic Vertebrae

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.....

Signature Jesse E. Deery (M. D. or other).....
Address Webb City Mo Date signed 9/6/47

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

47-9-760.

APR 8 1948

APR 6 1948

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 *Floyd Atkinson*
Licensed Embalmer No. *3920*
P. O. Address *Harrisonville*

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.