

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED JAN 17 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44214

State File No.

Registration District No. 53

Primary Registration District No. 5342

Registrar's No. 106

1. PLACE OF DEATH:

(a) County Deade
(b) City or town Rural Washington Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution life (Specify whether years, months or days)
In this community life

3. (a) PRINT FULL NAME David Lee James

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 S
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive 6 years (Day) (Year)
7. Birth date of deceased June 6 1945
(Month) (Day) (Year)

8. AGE: 2 Years 6 Months 4 Days If less than one day hr. min.

9. Birthplace So. Greenfield, MO.
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name Oscar James
13. Birthplace So. Greenfield, MO.
(City, town, or county) (State or foreign country)
14. Maiden name James
15. Birthplace Jasper Co.
(City, town, or county) (State or foreign country)

16. (a) Informant Oscar James
(b) Address So. Greenfield

17. (a) Burial (b) Date thereof Dec. 12, 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Penneshoro, MO

18. (a) Signature of funeral director W. R. Allison

(b) Address Greenfield, Mo

19. (a) 12-13-47 (b) W. R. Allison
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Deade
(c) City or town So. Greenfield
(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 Dec. day 10
year 1947 hour 2 minute 10 P.M.

21. I hereby certify that I attended the deceased from 12/10, 1947 to 12/10, 1947
that I last saw him alive on 12/10/47, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None seen

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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) (e) Means of injury

23. Signature W. R. Allison (M. D. or other)
Address Greenfield Date signed 12/11/47

RECEIVED
District Health Officer No. 64
District File Number 148-67
Date Filed JAN 14 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 W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. FebRegistrar's No. 106Registration District No. 93Primary Registration District No. 5342

1. PLACE OF DEATH:

- (a) County Dade
 (b) City or town Rural
 (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 NAMEDavid Lee James

3. (b) If veteran, _____
 name war _____

3. (c) Social Security
 No. _____

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

7. Birth date of deceased June
 (Month) (Day) (Year)

8. AGE: Years 2 Months _____ Days _____
 (Unless less than one day) _____ hr. _____ min.

9. Birthplace _____
 (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) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____
 (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 _____
 year 1945 hour _____ minute _____ M.

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

Duration

- Due to _____

- Due to _____

- 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 sta-
 tistically.

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 A. R. Cain M.D. (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY
Bronchial Pneumonia 2 days

44214