

No. 2  
8-43  
5-17-39  
X37823

FILED DEC 15 1948

Registration District No. **47**

Primary Registration District No. **3008**

Registrar's No. **349**

**1. PLACE OF DEATH:**  
 (a) County **Callaway**  
 (b) City or town **Hutton**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **State Hos No 1 2**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **414 3 m 17 d**  
(Specify whether  
 In this community **same**  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Mo** (b) County **Schuyler**  
 (c) City or town **Lancaster**  
(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 \_\_\_\_\_

**3. (a) PRINT FULL NAME** **JAMES H YMES**  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month **Dec** day **6**  
 year **1948** hour **9** minute **45** M.  
 21. I hereby certify that I attended the deceased from **Dec 5-1948** 19\_\_\_\_ to **Dec 6 1948** 19\_\_\_\_  
 that I last saw h. **alive** on **12/5/48** 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

4. Sex **mo** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **SO**  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

Immediate cause of death **hypnomania**  
 Duration \_\_\_\_\_

**8. AGE:** Years **60** Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

9. Birthplace **Unionville Mo** **6**  
(City, town, or county) (State or foreign country)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation **Laborer**  
 11. Industry or business **farm**

Major findings:  
 Of operations **1110**  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name **dk** **9**  
 13. Birthplace **dk** **9**  
(City, town, or county) (State or foreign country)  
 14. Maiden name **dk**  
 15. Birthplace **dk** **9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Joe Records**  
 (b) Address **Hutton Mo**  
 17. (a) **Removal** (b) Date thereof **12 15 48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Columbia Mo**

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_

18. (a) Signature of funeral director **J. O. Roberts**  
 (b) Address **Columbia Mo.**  
 19. (a) **12.10-1948** (b) **Joe Morsink**  
(Date received local registrar) (Registrar's signature)

(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? **0**  
 While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury  
 Signature **J. Caldwell** (M. D. or other) **mo**  
 Address **Hutton Mo** Date signed **12/6/48**

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

Date Filed -----  
DEC 14 1948  
District File Number -----

Director, Health Officer No. 9,

RECEIVED

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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..**