

FILED DEC 1 1948

Registration District No. 138

Primary Registration District No. 5522

Registrar's No. 43

1. PLACE OF DEATH:

(a) County Hickory  
(b) City or town Grass Timbers  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community Traveling Through By Car (years, months or days)

3. (a) PRINT FULL NAME JAMES DIMITRIOS ANDREAS MACINIS

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

4. Sex M Color or race W 5. (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 10 - 26 1892  
(Month) (Day) (Year)

8. AGE: Years 56 Months 1 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Nafplion, Spaziko, Greece  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant By Personal Belongings

(b) Address Removal (c) Date thereof 11-27-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rocky Mt. Cem. N. W. 1/4 Sec. 19, T. 11 N., R. 11 W., Mo.

18. (a) Signature of funeral director Albert Pathaway

(b) Address Wheatland, Mo.

19. (a) Nov 27 1948 (Date received local registrar) W. P. Hargiss (Registrar's signature) 121

2. USUAL RESIDENCE OF DECEASED:

(a) State MINNESOTA (b) County Olmsted  
(c) City or town Rochester 21  
(If outside city or town limits, write "RURAL")  
(d) Street No. 14 South Broadway 0  
(If rural, give location)  
(e) Citizen of foreign country? Not (Yes or No) 2  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death Skull fracture  
Right tibia left leg  
by Blown up

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

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

Other conditions Caud in chest  
(Include pregnancy within 3 months of death)  
Fractured left foot  
Right tibia  
Right thigh - mandible

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_ 43

(b) Date of occurrence 11-27-1948

(c) Where did injury occur? Grass Timbers, Hickory, Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Highway

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury Car accident

23. Signature Mervin Holt Coroner (M. D. or other) 3  
Address Hermitage Mo. Date signed 11-27-48

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Ran 11/27/48

RECEIVED

District Health Officer No. 7

District File Number 10-48-1379

Date Filed 11-30-48

DEC 9 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 *Chas Gilbert Hathaway*

Licensed Embalmer No. 4267

P. O. Address *Wheatland, MD*

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Dec  
Registrar's No. 43

Registration District No. 138 Primary Registration District No. 5522

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

1. PLACE OF DEATH:

(a) County Hickory

(b) City or town Cross Junction  
(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

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 \_\_\_\_\_

3. (a) PRINT FULL NAME James D. Amarnis

3. (b) If veteran, name wa \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 Day 27 year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

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 \_\_\_\_\_

7. Birth date of deceased: Dec 26 (Month) 1907 (Day) \_\_\_\_\_ (Year)

Immediate cause of death \_\_\_\_\_

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

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

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

8. AGE: Years 56 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Time Square State Capital

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)

MOTHER FATHER

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

13. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

5-36284