

FILED MAR 29 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7631

BIRTH NO. _____		REG. DIST. NO. 53		PRIMARY REG. DIST. NO. 3010		Registrar's No. 79	
<b>1. PLACE OF DEATH</b> a. COUNTY CAPE GIRARDEAU b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CAPE GIRARDEAU c. LENGTH OF STAY (in this place) 4 Days d. FULL NAME OF HOSPITAL OR INSTITUTION South East Mo. Hosp. U				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE Ma b. COUNTY BOLLINGER c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL BORANCE Twp d. STREET ADDRESS (If rural, give location) NEAR LUTESVILLE Mo.			
<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) ADAM b. (Middle) ✓ c. (Last) JAMES		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) 3 - 22 - 49		<b>5. SEX</b> M. 0		<b>6. COLOR OR RACE</b> W.	
<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) MARRIED		<b>8. DATE OF BIRTH</b> 2 - 23 - 1894		<b>9. AGE</b> (In years last birthday) 55 # UNDER 1 YEAR Months 0 Days 29 # UNDER 12 HRS. Hours Min.		<b>10. BIRTHPLACE</b> (State or foreign country) BOLLINGER Co. Mo.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) SAW MILL OPERATOR		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> —		<b>11. CITIZEN OF WHAT COUNTRY?</b> U.S.A.		<b>12. BIRTHPLACE</b> (State or foreign country) BOLLINGER Co. Mo.	
<b>13a. FATHER'S NAME</b> JOHN E. JAMES		<b>13b. MOTHER'S MAIDEN NAME</b> FANNIE M. EAKER		<b>14. NAME OF HUSBAND OR WIFE</b> DELPHA JAMES			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> NONE		<b>17. INFORMANT'S SIGNATURE OR NAME</b> DELPHA JAMES			
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) 237 <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.				<b>INTERVAL BETWEEN ONSET AND DEATH</b> 3 days unknown	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> 0				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.		<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 3-19, 1949, to 3-22, 1949, that I last saw the deceased alive on 3-21, 1949, and that death occurred at 4:30 A.M., from the causes and on the date stated above.</b>							
<b>23a. SIGNATURE</b> (Degree or title) C. F. McDonald, M.D.		<b>23b. ADDRESS</b> Jackson, Mo.		<b>23c. DATE SIGNED</b> 3-26-49			
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) BURIAL		<b>24b. DATE</b> 3-24-49		<b>24c. NAME OF CEMETERY OR CREMATORY</b> BAKER CEM.		<b>24d. LOCATION</b> (City, town, or county) (State) LUTESVILLE Mo.	
<b>DATE REC'D BY LOCAL REG.</b> 3-26-49		<b>REGISTRAR'S SIGNATURE</b> C. L. Summers		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> BAKER FUNERAL HOME			
				<b>ADDRESS</b> LUTESVILLE			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 4

District File Number 349-4

Date Filed 3-28

APR 1 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed

*J. E. Graham*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4010

P. O. Address Luttrellville, 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.