

FILED NOV 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35604
STATE FILE NUMBER

Registration District No. 140 Primary Registration District No. 5547 Registrar's No. 91

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>R.F.D. # 4</u> <u>Fayette</u> TOWN Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY <u>Fayette</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR R.F.D. # <u>4</u> Institution Length of stay in 1b Years		d. STREET ADDRESS R.F.D. # <u>4</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last (Type or print) <u>James Crafford York</u>			4. DATE OF DEATH Month Day Year <u>Oct. 7 1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-21-1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Batesville, Arkansas</u>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>Mattie Mo Holland</u>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Hettie Buckler, Columbia, Missouri</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Head</u> <u>(Self-inflicted Wound)</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>(Self-inflicted Wound)</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Shot self with pistol.</u>	
20c. TIME OF INJURY Hour Month, Day, Year? a.m. ? <u>02:17-1957</u> p.m. ?		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> AT WORK		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Fayette / Howard MO</u>	
21. I attended the deceased from <u>10-20-57</u> to <u>10-20-57</u> and last saw her alive on <u>10-20-57</u> Death occurred at <u>5:30</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. Bloom M.D.</u>		22b. ADDRESS <u>Fayette MO</u>	
22c. DATE SIGNED <u>10-23-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-20-1957</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Parker Funeral Service, Columbia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10/23/57</u>	
26. REGISTRAR'S SIGNATURE <u>Mary L. Shell</u>			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

MS OCT 14 1959

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.

Student
Signature of Student Embalmer

Signed *Wm. E. Treese*

Licensed Embalmer No. *4870*

P. O. Address *Hayette*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.