

Health, Welfare
Public Service

FILED MAR 21 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009042
STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 262

1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Butler</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Poplar Bluff</u> <u>0124</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1014 Butler</u>		Length of stay in lb <u>4 mo.</u>	d. STREET ADDRESS (If outside, give location) <u>1014 Butler</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JIM</u> Middle <u>D.</u> Last <u>JAMES</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>21,</u> Year <u>1958</u>		
--	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1890</u>	9. AGE (In years last birthday) <u>66</u>	FUNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min.	IF UNDER 24 HRS. Hours <u>1</u> Min.
-----------------------	----------------------------------	---	--	--	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Owensboro, Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	--	-----------------------------------	--	---

13a. FATHER'S NAME <u>Jessie M. James</u>		13b. MOTHER'S MAIDEN NAME <u>Sadie Bell Hedrick</u>	14. NAME OF HUSBAND OR WIFE <u>Ruby James</u>
--	--	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>345-09-4543</u>	17. INFORMANT <u>Ruby James, 1014 Butler, Poplar Bluff Mo</u> Address
--	---	---

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>Cerebral occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis heart disease 5 yrs.</u>	
	DUE TO (c) _____	
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? <u>0</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Poplar Bluff, Mo</u>	COUNTY _____	STATE _____
---	--	--	---	--------------	-------------

21. I attended the deceased from <u>10 Dec 58</u> to <u>21 Feb 58</u> and last saw her alive on <u>19 Feb 58</u> Death occurred at <u>2:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Deceased or title) <u>Opal A. Pat M.D.</u>	22b. ADDRESS <u>Poplar Bluff, Mo</u>	22c. DATE SIGNED <u>11 March 58</u>
---	---	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-25-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brown Chapel Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Broseley, Mo. Rte. 1</u>
--	-----------------------------	--	--

24. FUNERAL DIRECTOR <u>Landess Funeral Home, Campbell, Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>3/15/58</u>	26. REGISTRAR'S SIGNATURE <u>R. M. ...</u>
---	---------	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in Part 18. All diseases in Part 1 must be causally related.

300
-57

RECEIVED

MAR 18 1958
BUTLER CO. HEALTH CENTER

FILE No. _____

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 *Christina M. Landes*

Licensed Embalmer No. *4227*

P. O. Address *Campbell*

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.