

FEB 24 1933

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

485

1. PLACE OF DEATH

County Cape Girardeau
Township Boyd
City Jackson (No. _____)

Registration District No. 124
Primary Registration District No. 4070

File No. _____
Registered No. 3
St. _____ Ward _____

2. FULL NAME

James F Underwood

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Stella Underwood

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
75 unknown unknown or

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired day labour
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Louisiana Mo.

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

14. INFORMANT Stella Underwood

(Address) Jackson Mo.

15. FILED 1-12-33 D. G. Silva

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-10-1933

17. I HEREBY CERTIFY, That I attended deceased from 1-6-33 to 1-10-33, 1933, and that I last saw him alive on 1-9-33, 1933, and that death occurred, on the date stated above, at 5:30 A. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

HE
97
Duration yrs. mos. ds. 5 ds.

CONTRIBUTORY (SECONDARY) arteriosclerosis

(duration) 1 yrs. 4 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) D. R. Schwan, M. D.

1-12-1933 (Address) Jackson Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

City unknown Jackson Mo. June 12 1933

UNDERTAKER

Crawford Miller Jackson Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

CONFIDENTIAL - SECURITY INFORMATION



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SECRET

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