

JAN 8 1939

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

43616
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 100
(b) Township Spring Primary Registration District No. 55530 Registered No. 219
(c) City Little Blue, Mo. (d) Street No. Jackson County home for the aged St. At death occurred in Hospital, Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 230 Charles Cusick St. JC home (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 26 - 1863

7. AGE YEARS 76 MONTHS 0 DAYS 1 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Solomon
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

FATHER 13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Samuel Jackson
JC home

18. BURIAL, CREMATION, OR REMOVAL K6 local of cert & engr DATE Nov 1 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. B. Miller
K6 mo

20. FILED 11-5-39 Sam H. Barnes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 27 1939

22. I HEREBY CERTIFY, That I attended deceased from 10-23, 1939 to 10-27, 1939

I last saw h. = alive on 10-27, 1939 Death is said to have occurred on the date stated above, at 2:30 a.m.

The principal cause of death and related causes of importance were as follows:

Chronic Myo carditis Date of onset

Other contributory causes of importance: None

Name of operation Divical Date of Nov
What test confirmed diagnosis Divical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

(Signed) J. H. Barnes, M. D.
(Address) Independence

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.

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.....

Wm L Ward

Licensed Embalmer No. *3991*

P. O. Address. *5725 Virgi*

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, above space should be left blank.