FILED JUN 10 1940

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

17908
Do not use this space.

1. PLACE OF DEATH
(a) County BUCHANAN 3 Registration District No. 85
(b) Township or City ST-JOSEPH Primary Registration District No. 1001 Registered No. 552
(c) (d) Street No. St. Hospital #2 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 7 yrs. 3 mos. 18 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Dr. James Pew
(a) Residence, No. State Hospital #2 St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): separated
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Ethel (Reed) ~~[illegible]~~
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Sept. 2, 1893
7. AGE: YEARS 46 | MONTHS 8 | DAYS 12 | If LESS than 1 day, ...hrs. or ....min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ill. unk 9

FATHER
13. NAME: James Pew 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio unk 9

MOTHER
15. MAIDEN NAME: Laura Isab. Green
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ill. unk

17. INFORMANT (ADDRESS): Mrs. Fred Base R. 2, Gypsum Kan.
18. BURIAL, CREMATION, OR REMOVAL
PLACE State Hosp. Cemetery DATE May 15, 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Roy Stanley 85 St. Joseph Mo.
20. FILED 5/15/40 H. J. Nestlebusch Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 14, 1940
22. I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1933, to May 14, 1940
I last saw him alive on " " , 1940. Death is said to have occurred on the date stated above, at 12-59 m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Gen. paralysis of the insane (syphilitic meningo encephalitis)	1932

Other contributory causes of importance: 83

Name of operation: none Date of —
What test confirmed diagnosis? Clinical 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) T. E. Dell, M. D.
(Address) St. Joseph

(Licensed Embalmer's Statement on Reverse Side)

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.

I X16605

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

Cedric K Jones, Registered Apprentice No. 246

working under my personal supervision.

Signed John Roy Stamey

Licensed Embalmer No. 2435

P. O. Address St Joseph Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.