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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

23273  
State File No. \_\_\_\_\_  
Registrar's No. 5625

**FILED** AUG 28 1941 791  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: De Paul Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 weeks  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Geo. M. JAMES

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mabel James 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased May 18 1879  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>62</u>	<u>12</u>	<u>1</u>	<u>16</u>	_____ hr. _____ min.

9. Birthplace Romsey, Mississippi Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired merchant

11. Industry or business \_\_\_\_\_

12. Name T. M. JAMES

13. Birthplace Fayette, Ill.  
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Blankenship

15. Birthplace Fayette Co., Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Robert James (son)  
(b) Address St. Louis, Mo.

17. (a) REMOVAL (b) Date thereof July 20 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Salem, Ill.

18. (a) Signature of funeral director Hanson of Funeral Home  
(b) Address Salem, Illinois

19. (a) JUL 8 1941 (b) J. W. B. Beck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 999 11

(a) State Ill. (b) County \_\_\_\_\_

(c) City or town Salem NR  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1 -  
year 1941 hour 8:30 minute P. M.

21. I hereby certify that I attended the deceased from May 27 1941 to July 1 1941;  
that I last saw him alive on July 1 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic - Crystalline glomerulonephritis

Due to (Pituitary Disease)

Due to \_\_\_\_\_

Other conditions 1250  
(Include pregnancy within 3 months of death)

Major findings: Chronic Crystalline glomerulonephritis

Of operations antitoxin

Of autopsy same

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature J. W. B. Beck (M. D. or other) P  
Address 4952 Maryland Date signed \_\_\_\_\_

SEP 1 8 1940

SEP 22 1940

56295

56295

**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.....

*John Kellie*  
.....  
Licensed Embalmer No. 3850

P. O. Address.....

**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, fact should be so stated above.

*Thompson*  
4952 Mergle