

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27635  
Registrar's No. 78

FILED SEP 11 1942  
Registration District No. 280

Primary Registration District No. 2725

6100  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County MACON

(b) City or town MACON HILLSBORO  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
STILL-HILDRETH SANATORIUM  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7/4/42 to 8/21/42  
(Specify whether)

In this community -  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County MACON

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

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

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME DR. GLICE K. JAMES

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24  
year 1942 hour about minute 5 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife DR. J. W. JAMES 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Mar 9 - 1896  
(Month) (Day) (Year)

that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death STRAUSGUBATION  
caused by tying oxygen smock  
AROUND HEAD RAILING OF BED, AND  
Due to OTHER END AROUND NECK; SAUMP  
INS TO HER KNEES ON FLOOR.

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>5</u>	<u>15</u>	hr. _____ min. _____

Other conditions \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

9. Birthplace Providence Mass  
(City, town, or county) (State or foreign country)

10. Usual occupation Doctor of Osteopathy

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

12. Name Edgar T Knowles

13. Birthplace Dont know 9  
(City, town, or county) (State or foreign country)

14. Maiden name Carrine James

15. Birthplace Dont know 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Dr J. W. James

(b) Address 507 E 7th St Ralla mo

17. (a) burial (b) Date thereof Aug 26-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn ceme

18. (a) Signature of funeral director Robert Skyrman

(b) Address Macon

19. (a) 9/4/42 (b) Pratt B. Shunkler  
(Date received local registrar) (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence 8-24-42

(c) Where did injury occur? MACON MACON Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
STILL-HILDRETH SANATORIUM  
(Specify type of place)

While at work? PATIENTS (e) Means of injury HANGING

23. Signature N. S. Edmund  
Address Bevier Mo Date signed 8/24/42

RECEIVED

District Health Officer No. 10

District File Number 9-42-1706

Date Filed SEP - 8 1942

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 *Albert Skinner*

Licensed Embalmer No. 75-1

P. O. Address *Macon mo*

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.