

FILED MAR 9 1945  
Registration District No. 4/2

Primary Registration District No. 1000

1. PLACE OF DEATH: Buchanan  
(a) County Buchanan  
(b) City or town St. Joseph, Missouri.  
(c) Name of hospital or institution: Missouri Methodist Hospital--126  
(If not in hospital or institution, write street number or location) Two days.  
(d) Length of stay: In hospital or institution Fifty years.  
In this community \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph.  
(d) Street No. 1220 Powell Street  
(If rural, give location) No. 7  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME DAVID SMITH AMES.  
(b) If veteran, NO (c) Social Security No. NO.  
name war. NO.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb day 15th.  
year 1945 hour 4 minute 55 P. M.

4. Sex MALE (5) Color or race WHITE  
6. (a) Single, widowed, married, divorced DIV.  
6. (b) Name of husband or wife JENFIE AMES  
6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased February 5th. 1874  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 13 1945 to Feb. 15 1945  
that I last saw him alive on Feb. 15 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage 36hr.  
Due to: Hypertensive arterio-sclerotic cardio-vascular disease  
Due to: (Pt. Hemiplegia)Other conditions: Obesity  
(Include pregnancy within 3 months of death)Duration

8. AGE: Years 71 Months 0 Days 11  
If less than one day hr. -- min. --

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace Brookfield Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Railroad - C.B. & O.

11. Industry or business James Ames.

MOTHER FATHER  
12. Name \_\_\_\_\_ 9  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Emma Root  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Carl Walker.  
(b) Address 1220 Powell Street.

17. (a) Burial (b) Date thereof Febr. 19, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Mrs. E. R. Sidenfaden  
(b) Address 602 South 10th Street

19. (a) 2-17-45 (b) Helen A. Nichol  
(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) \_\_\_\_\_  
(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 B. J. Grant M.D. (Date or other) \_\_\_\_\_  
Address St. Joseph, Mo. Date signed 2-16-45

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

**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 *Mollie E. Sidenaden Fox*

Licensed Embalmer No. *4235*

P. O. Address. *St. Joseph, 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.**