

FILED MAY 4 1945

State File No. \_\_\_\_\_

Registration District No. 219

Primary Registration District No. 5791

Registrar's No. 4

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

1. PLACE OF DEATH:  
(a) County Moniteau Burns Fork Twp.  
(b) City or town Russellville Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community Life \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Moniteau 68  
(c) City or town Rural Russellville Mo. 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5 Mi. West 0  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Monroe Amos

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month April day 21, 1945  
year \_\_\_\_\_ hour 3 minute \_\_\_\_\_ P. M.

4. Sex Male 5. Color or race W  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Cecelia Ann Amos 6. (c) Age of husband or wife if alive 80 years  
7. Birth date of deceased: March 22 1860  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 14, 1945, to April 21, 1945  
that I last saw him live on April 21, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Apoplexy 7 days  
Duration \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
85 29

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

9. Birthplace: Cole County, Mo. (City, town, or county) (State or foreign country)

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

10. Usual occupation Farmer

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

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

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

12. Name Benjamin Amos

13. Birthplace Cole Co. Mo. (City, town, or county) (State or foreign country)

14. Maiden name Sarah Roark

15. Birthplace Cole, Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant T. C. Amos

(b) Address Russellville, Mo.

17. (a) ~~Place of burial~~ (b) Date thereof April 23, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Deloe Cem.

18. (a) Signature of funeral director: Walter L. Schube

(b) Address Russellville, Mo.

19. (a) April 23-45 (b) Mr. E. W. Plummer  
(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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Walter L. Leslie (M. D. or other) \_\_\_\_\_

Address Russellville Mo Date signed 4-23-45

PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed.....

5-3-45

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. 2820,  
working under my personal supervision.

Signed.....



Licensed Embalmer No. 2820.....

P. O. Address Russellville, 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.