

3. No. 2
-12-45
5-17-39
I X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43316**
Registrar's No. **166**

Registration District No. **360** Primary Registration District No. **6225**

1. PLACE OF DEATH:
(a) County **Lemon**
(b) City or town **Stroads rural Wash.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **State Hospital #3.2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 1/2 - 10 1/2 Day**
(Specify whether years, months or days) **5 1/2 - 10 1/2 Mos 1 Day**

3. (a) PRINT FULL NAME **Peter James (TAMS)**
3. (b) If veteran, name war **?**
3. (c) Social Security No. **None**

4. Sex **M** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **?**
6. (c) Age of husband or wife if alive **?** years
7. Birth date of deceased **9-2-1865**
(Month) (Day) (Year)

8. AGE: Years **81** Months **3** Days **26**
If less than one day hr. min.

9. Birthplace **Germany** yrs **4**
(City, town, or county) (State or foreign country)

10. Usual occupation **None stated**

11. Industry or business **21-76**

MOTHER FATHER
12. Name **Detlef James**
13. Birthplace **Germany** yrs **4**
(City, town, or county) (State or foreign country)
14. Maiden name **Wespa Seiver**
15. Birthplace **Germany** yrs **11**
(City, town, or county) (State or foreign country)

16. (a) Informant **Records**
(b) Address **State Hospital #3**

17. (a) **Burial** (b) Date thereof **12/29/1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Maple Park Cemetery**

18. (a) Signature of funeral director **ALMA LOHMEYER FUNERAL HOME**
Springfield, Missouri
(b) Address

19. (a) **12-31-46** (b) **Kathryn Hancy**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Green** 108
(c) City or town **Springfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **21-76**
(If rural, give location)
(e) Citizen of foreign country? **Yes** (Yes or No)
If yes, name country **Germany**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12-** day **28**
year **1946** hour **12:25** minute **A.** M.
21. I hereby certify that I attended the deceased from **12-26-** 19**46**, to **12-28-** 19**46**
that I last saw him alive on **12-27-** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death
Due to **Chronic Heart Disease**
Due to **General Arteriosclerosis**
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations **930**
Of autopsy

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 **0**
23. Signature **M. Bunch** (M. D. or other)
Address **State Hospital #3** Date signed **12-28-46**

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

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

331

(Licensed Embalmer's Statement on Reverse Side)

1-2-71
12-46-20x

RECEIVED

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 L. A. Paul

Licensed Embalmer No. 3044

P. O. Address Springfield, Missouri

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.