

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Texas
Township _____
or
Village St. Clair Mo
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 294 File No. 12795
Primary Registration District No. 4178 Registered No. 10

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Benjamin B. Jones

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Sept 19, 1819
(Month) (Day) (Year)

AGE 90 yrs. 7 mos. 15 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Practitioner
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) St. Charles Co Mo.

PARENTS
NAME OF FATHER John Jones
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER Mary Thornhill
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Bringle

(ADDRESS) St. Clair

Filed May 10 1910 W. E. Kitchell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 4, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased ~~from~~ on May 4, 1910, to May 4, 1910, that I last saw him alive on May 4, 1910, and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
97 (Duration) ___ yrs. ___ mos. One ds.

Contributory arteriosclerosis
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) C. F. Bringle M. D.
May 5, 1910 (Address) St. Clair Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the ___ State ___ yrs. ___ mos. ___ ds.
Where was disease contracted If not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Prophet-Courtesy DATE OF BURIAL May 6, 1910
UNDERTAKER W. E. Kitchell ADDRESS St. Clair Mo

