

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

PLACE OF DEATH
County North
Township Green
Age _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 903 File No. 19031
Primary Registration District No. 6214 Registered No. 10

FULL NAME Walter W. Jones

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
DATE OF BIRTH Dec. 12, 1888
(Month) (Day) (Year)

AGE 21 yrs. 5 mos. 1 ds. IF LESS than
1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE
(City or town, State or foreign country) North Co

PARENTS
NAME OF FATHER William Jones
BIRTHPLACE OF FATHER Mo
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Josephine Allen
BIRTHPLACE OF MOTHER Mo
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Jones
(ADDRESS) Grout City Mo
Filed 6/6 1910 John Adams REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 13, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mo, 1910, to Mo, 1910,
that I last saw h deceased, 1910,
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
23A
(Duration) 5 yrs. ____ mos. ____ ds.

Contributory
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) ____ M.D.
1910 (Address) ____

*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 Grout Cemetery DATE OF BURIAL May 15, 1910
UNDERTAKER Orn Prugh ADDRESS Grout City

PLACE OF DEATH

County _____

Township _____
of _____

Village _____

or _____

City _____

(NO _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

St. _____

Ward _____

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

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (<i>write the word</i>)

DATE OF BIRTH _____

(Month) _____, 191____ (Day) _____ (Year) _____

AGE _____

IF LESS than
1 day, _____ hrs.
or _____ min.?

OCCUPATION _____

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

BIRTHPLACE _____

(City or town, _____
State or foreign country)

NAME OF FATHER _____

BIRTHPLACE OF FATHER _____

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER _____

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____

191____

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

(Month) _____, 191____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Contributory _____

(SECONDARY)

(Signed) _____ (Address) _____ M. D. _____

PARENTS

*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury, and (2) whether Accidental, Social, or Homicidal.LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR
RECENT RESIDENTS) _____

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted
if not at place of death? _____Former or
usual residence _____

(Informant) _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____, 191____

UNDERTAKER _____

ADDRESS _____