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 Newton

Township Franklin
or
Village ~~Fairview Mo~~
or
City (NO. St.: Ward)

Registration District No. 608 File No. 5 5917

Primary Registration District No. 5807-a Registered No.

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

FULL NAME John B Jones

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)

DATE OF BIRTH: March 15, 1871 (Month) (Day) (Year)

AGE: 46 yrs. 10 mos. 28 ds. 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) Farmer

BIRTHPLACE (City or town, State or foreign country) Verona Mo

PARENTS
NAME OF FATHER: Peter Jones
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ill
MAIDEN NAME OF MOTHER: Mrs Jones
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charly Jones

(ADDRESS) Verona Mo

Filed 2/13, 1918 L. N. Pannell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb 12th, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 31, 1918, to Feb 12, 1918, that I last saw him alive on the 11th Feb, 1918, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Appendicites

121B

108

(Duration) ___ yrs. ___ mos. 14 ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) S A Russell M. D.

Feb 13, 1918 (Address) Fairview 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: Leamy Barnes Mo Leamy Springhill

DATE OF BURIAL: ___, 191__

UNDERTAKER: White & Pogue

ADDRESS: Fairview Mo

MISSOURI STATE BOARD
BUREAU OF VITAL STAT
CERTIFICATE OF DEAT

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. .... St.; ..... Ward)

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day) ..... (Year)

AGE ..... yrs. ..... mos. ..... ds. | 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)

PARENTS

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

MEDICAL CERTIFICATE OF DE

DATE OF DEATH

..... (Month)

I HEREBY CERTIFY, that I att

....., 191....., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stat

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs.

Contributory .....
(SECONDARY)
..... (Duration) ..... yrs.

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deathi (1) Means of Injury: and (2) whether Accidental, Suicid

LENGTH OF RESIDENCE (FOR HOSPITALS, INS RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State .....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL

UNDERTAKER