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 Henry

Township Springfield Registration District No. 356 File No. 23072

or Village Primary Registration District No. 5588 Registered No.

or City (No. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Wm M. Jones

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
SEX: Male. COLOR OR RACE: White. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married	DATE OF DEATH: July (Month) 1 (Day), 1918 (Year)
DATE OF BIRTH: Dec. (Month) 30 (Day), 1843 (Year)	I HEREBY CERTIFY, that I attended deceased from Jan 28, 1918, to May 24, 1918, that I last saw him alive on May 28, 1918, and that death occurred, on the date stated above, at 3 P m.
AGE: 74 yrs. 6 mos. 1 ds. If LESS than 1 day, ... hrs. or ... min.?	The CAUSE OF DEATH* was as follows: Organic Heart Dis. Acute Parenchymatous Nephritis (Duration) ... yrs. 10 mos. ... ds.
OCCUPATION (a) Trade, profession, or particular kind of work: Farmer. (b) General nature of industry, business, or establishment in which employed (or employer): Good	Contributory (Secondary) (Duration) ... yrs. ... mos. ... ds.
BIRTHPLACE (City or town, State or foreign country): Henry Co. Mo.	(Signed) R. F. Jennings M. D. 7-2, 1918 (Address) Windsor Mo
NAME OF FATHER: Richard Jones	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
BIRTHPLACE OF FATHER (City or town, State or foreign country): Va.	LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
MAIDEN NAME OF MOTHER: Charity Dobdson	Where was disease contracted if not at place of death?
BIRTHPLACE OF MOTHER (City or town, State or foreign country): S. C.	Former or usual residence
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs Wm M Jones (Address) Windsor Mo	PLACE OF BURIAL OR REMOVAL: Tebo Cemetery. DATE OF BURIAL: 7-2, 1918
Filed 8-10-, 1918 J. P. Allen M.D. REGISTRAR	UNDERTAKER: H. G. Huston. ADDRESS: Windsor

9214 138

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....

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

Registration District No..... File No.....

Primary Registration District No..... Registered No.....

(NO..... St.;.....Ward)

[If death occurre hospital or insti give its NAME of street and num

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

....., 1.....
(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 DEATH

DATE OF DEATH

....., ...
(Month) (Day)

I HEREBY CERTIFY, that I attended deceased

....., 191....., to....., 1

that I last saw h.....alive on....., 1

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory.....
(SECONDARY)

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

(Signed).....

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS RECENT RESIDENTS)

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 19
UNDERTAKER	ADDRESS

WALLACE CROSSLEY
LIEUTENANT GOVERNOR
WALTER C. GOODSON
PRESIDENT PRO TEM.
ROBT. E. L. HARRIS
SECRETARY

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

...information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ...