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 Jasper

Township Poplar

or Village

or City Carterville (No. ____ St.; ____ Ward)

Registration District No. 407 File No. 29618

Primary Registration District No. 4 Soft Registered No. 49

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

FULL NAME Luther Martin Jones.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Abrut (Month) (Day) 890 (Year)

AGE Abrut 28 yrs. ____ mos. ____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS

NAME OF FATHER C. R. Jones

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill

MAIDEN NAME OF MOTHER Nollie Bliss

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. C. Jones

(ADDRESS) Webb City Mo

Filed 9/29, 1918. J. R. Barry, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept (Month) 25 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from ____ 191__ to ____, 191__, that I last saw him ~~alive~~ in Dead on Sept 26, 1918, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

Ruptured Left Kidney & Spleen

Internal Hemorrhage

1946 (Duration) ____ yrs. ____ mos. ____ ds.

Contributory unknown (SECONDARY)

1036 (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A. L. Carpenter M. D.

Sept 26, 1918 (Address) Cooner

*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 Carterville Cem

DATE OF BURIAL Sept 29, 1918

UNDERTAKER Webb City Mud Co

ADDRESS Webb City

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... 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 .....

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.

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

....., 191.....
(Month) (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:

.....

.....

.....

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

Contributory .....
(SECONDARY)

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

(Signed) ..... M. D.

....., 191..... (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	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS