LOCAL REGISTRAR'S RECORD DO NOT DETACH

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

15284

1 PLACE OF DEATH

County: Stone

Township: Grant

or

Village:

or

City: (NO. St.; Ward)

Registration District No. 1068

Primary Registration District No. 6105

File No.

Registered No.

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

2 FULL NAME Isaac Gerald Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6 DATE OF BIRTH: Oct (Month) 6 (Day) 1900 (Year)

7 AGE: 1 yrs. 5 mos. 1 ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Stone Co Mo

PARENTS

10 NAME OF FATHER: Roy Jones

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Stone Co Mo

12 MAIDEN NAME OF MOTHER: Gertie Ellis

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Stone Co Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Ema Ellis
(Address): Huxley Mo

15
Filed March 25 1920 B. F. Smart
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 7 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb-25-, 1920, to Mch-7-, 1920, that I last saw him alive on Mch-7-, 1920, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:
Influenzal Meningitis
11B

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): Influenza
(Duration) yrs. mos. 12 ds.

(Signed) W. L. Kew M. D.
3-8-, 1920 (Address) Crane

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Wright Cemetery

DATE OF BURIAL: 3-8-, 1920

20 UNDERTAKER: W. E. Tilton

ADDRESS: Crane

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 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.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

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.