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

33731

PLACE OF DEATH

County: Monroe

Township: Clay
or
Village:
or
City: (NO. St.: Ward)

Registration District No. 578

Primary Registration District No. 5782

File No.

Registered No. 42

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

FULL NAME No name

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	S

DATE OF BIRTH: November (Month) 21 (Day), 1923 (Year)

AGE: ____ yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or 10 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): Holliday Mo.

PARENTS

NAME OF FATHER: Clay B. Jones

BIRTHPLACE OF FATHER (City or town, State or foreign country): Holliday. Mo.

MAIDEN NAME OF MOTHER: Lulu Hartman

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. Jones

(ADDRESS) Holliday Mo.

Filed 11/23/23 191__. Mrs. E. Baker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: November (Month) 21 (Day), 1923 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 21, 1923, to Nov 21, 1923, that I last saw him alive on Nov 21, 1923 and that death occurred, on the date stated above, at 9:40 P.m.

The CAUSE OF DEATH* was as follows:

Blue-baby

1572 1540

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

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

(Signed) E. Baker M. D.

Nov 23, 1923 (Address) Holliday 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	DATE OF BURIAL
Holliday Mo	Nov 23, 1923
UNDERTAKER	**ADDRESS**
Fred Thompson	Madison, Mo.

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 _____

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**

N. B.—Every item of information should be carefully [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION [illegible]