LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

21294

1 PLACE OF DEATH

County Macon

Township or Village ~~Ethel Mo~~ or City Bevier (NO. ..... St.; ..... Ward)

Registration District No. 527 File No. .....

Primary Registration District No. 4313 Registered No. 28

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

2 FULL NAME Mary Jane Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Wife of John M. Jones Feb (Month) 9 (Day) 1882 (Year)

7 AGE: 43 yrs. 4 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry business, or establishment in which employed (or employer): Domestic

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

PARENTS

10 NAME OF FATHER: John B Edwards

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

12 MAIDEN NAME OF MOTHER: Elizabeth Jane Evans

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J M Jones
(Address) Ethel Mo

15 Filed July 10, 1925 J L Williams Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 5 (Day) 1925 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 6-26, 1925, to 7-5, 1925, that I last saw her alive on 7-5, 1925 and that death occurred, on the date stated above, at 9 45 p. m.

The CAUSE OF DEATH* was as follows:
1st Chronic Nephritis
9 38
77
(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis
Myocarditis
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) R. P. Donovan M.D.
July 10, 1925 (Address) Bevier Mo

*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: Glastown Cemetery DATE OF BURIAL: July 7, 1925

20 UNDERTAKER: [illegible] ADDRESS: Ethel Mo

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 .....

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

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

6 DATE OF BIRTH
..... (Month) ..... (Day) ....., 1..... (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