

MAR 25 1927.

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

Do not use this space.

5359

1. PLACE OF DEATH,

County *Livingston*Registration District No. *515*Township *Blue Mound*Primary Registration District No. *5683*File No. *3*

City

Registered No.

St. _____ Ward)

2. FULL NAME *William J Jones*

(a) Residence No. _____ St. _____ Ward _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OF*Hanna Jones*6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 15 1838*

7. AGE

YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<i>88</i>	<i>5</i>	<i>29</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Farmer*

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Wales*10. NAME OF FATHER *Dont Know*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Dont Know*12. MAIDEN NAME OF MOTHER *Dont Know*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Dont Know*

14.

INFORMANT *John R Jones*(Address) *RR 1 Dawson*

15.

FILED *7/5 1927**J. H. Fullerton*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 14 1927*

17.

I HEREBY CERTIFY That I attended deceased from *Jan 26 1927* to *Feb 14 1927*, and I last saw him alive on *Feb 14 1927*, and that death occurred, on the date stated above, at *7:35 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chronic Interstitial Myocarditis*CONTRIBUTORY *Broncho pneumonia*

(SECONDARY)

(duration) yrs. mos. *2* da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, *at place of death*{ DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____WAS THERE AN AUTOPSY? *no*WHAT TEST CONFIRMED DIAGNOSIS? *J. L. Harlan*(Signed) *J. L. Harlan*, M. D.*Feb 14 1927* (Address) *Dawson MO*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

*Welsh Cem**2-16 1927*

20. UNDERTAKER

ADDRESS

H. B. Norman Chellieville

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS.

