

SEP 20 1927

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

Do not use this space

1. PLACE OF DEATH

County Osage  
Township Orbunford  
City (No. ....) .....

Registration District No. 640  
Primary Registration District No. 5849

File No. 27943  
Registered No. 18  
St. .... Ward)

2. FULL NAME

Gerilda Kansas Jones

(a) Residence (Usual place of abode) ..... Ward: ..... (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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 4 1927

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

17. I HEREBY CERTIFY, That I attended deceased from April 1927 to Sept 4 1927 that I last saw her alive on Sept 4 1927, and that death occurred, on the date stated above, at 2 a. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 10 - 1859

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Carcinoma of the stomach

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
68 1/4 24

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work House work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

CONTRIBUTORY (SECONDARY) J.F. Jones (duration) yrs. mos. da. (duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER Aquilla E. Jones

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

19. WHAT TEST CONFIRMED DIAGNOSIS..... (Signed) J.F. Jones M.D.

12. MAIDEN NAME OF MOTHER Arminia S. Bryan

(Address) Sept 4, 1927 Lison Mo.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

\*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. (See reverse side for additional space.)

14. INFORMANT J.F. Jones (Address) Lison Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19

15. FILED Sept 5 1927 Nora Jett REGISTRAR

20. UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, if may help, partly classified. Exact statement of OCCUPATION is very important.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Osage Registration District No. 440 File No. ....  
 Township Crawford Primary Registration District No. 3-8-49 Registered No. 18  
 City..... (No.....) St. .... Ward)

**2. FULL NAME**

Guilda Kansas 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 10 - 1899

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
67 x 11 24 6

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... ds.  
 (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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED Sept 24 1927 Hara Jett

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 4 19 27

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19..... (that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19 (Address)

\*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

Leine, Mo. Sept 5 19 27

20. UNDERTAKER Louis Bonnot Leine Mo.

PHYSICIANS should state CAUSE OF DEATH in plain language, but not in technical terms, unless the cause is specifically classified. By REGISTRATION SHALL NOT RECEIVE A

SUPPLEMENTARY

S-27943