

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

Do not use this space.

36310 - a

20 1927

**1. PLACE OF DEATH**

County Colfax Registration District No. 201  
 Township Liberty Primary Registration District No. 5280  
 City Liberty (No. 2017) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 98  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Eljah Jones

(a) Residence. No. X State Mo Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2007 Home 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) 1

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
68 | 7 | \_\_\_\_\_ | \_\_\_\_\_

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Inmate  
 (b) General nature of industry, business, or establishment in which employed (or employer) I.O.F. Home  
 (c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER John Jones

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

12. MAIDEN NAME OF MOTHER Rena Jones

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

14. INFORMANT (Address) Paul R. Rogers  
Liberty Mo

15. FILED 11/28 19\_\_\_\_ W. G. Goodson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 3 1927

17. I HEREBY CERTIFY, That I attended deceased from April 19\_\_\_\_ to Dec 3 19\_\_\_\_  
 that I last saw him alive on Dec 3 19\_\_\_\_ and that death occurred, on the date stated above, at 11 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Cancer of liver  
53 E

CONTRIBUTORY (SECONDARY) 44 (duration) 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

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

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

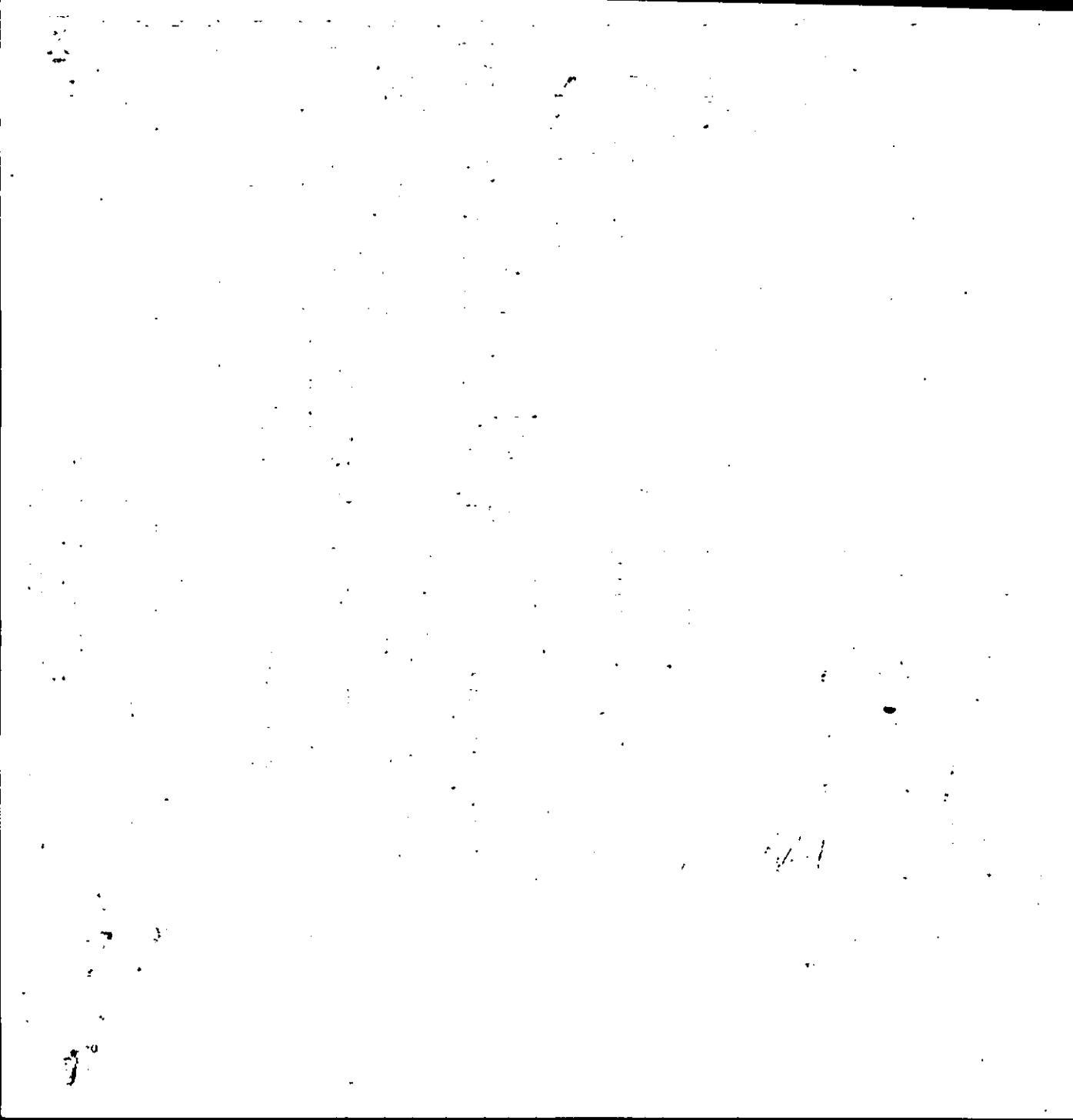
WHAT TEST CONFIRMED DIAGNOSIS? F.H. Matthews (Signed) \_\_\_\_\_, M. D.  
Dec 8, 19\_\_\_\_ (Address) Liberty Mo

\*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 I.O.F. Home Cemetery DATE OF BURIAL 12/4 1927

20. UNDERTAKER Church Lumber Co ADDRESS Liberty Mo

PARENTS



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Clay ..... Registration District No..... 201 ..... File No.....  
Township..... Liberty ..... Primary Registration District No..... 3012 ..... Registered No..... 98  
City..... Liberty (No. ....) St. .... Ward)

**2. FULL NAME**

(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.

Eligah Jones

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) X taken X

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May \* taken 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min. \* taken X

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work .....  
(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 3/10/28 Wmuff Gordon REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 3 1927

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:**

..... (duration)..... yrs. .... mos. .... ds.  
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  
19

20. UNDERTAKER ..... ADDRESS

**SUPPLEMENTARY**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-96310-A