27 1928

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

Do not use this space.

27888

1. PLACE OF DEATH

County Marion — Registration District No. 547 — File No. 222

Township Mason — Primary Registration District No. 3029 — Registered No.

City Hannibal (No. St. Elizabeth Hospital St. 6 Ward)

2. FULL NAME Joseph Le Roy Jones

(a) Residence. No. 3918 Westminster St., Ward. St. Louis Mo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 19-1914

7. AGE: Years 14 — Months 1 — Days 2 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(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) Springfield Ill

PARENTS

10. NAME OF FATHER: William Ora Jones
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ralls Co. Mo.
12. MAIDEN NAME OF MOTHER: Ethel Krighbaum
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ralls Co. Mo.

14. INFORMANT: William Ora Jones
(Address) St. Louis Mo.

15. FILED 8/24 1928 C. E. Strode M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 21- 1928

17. I HEREBY CERTIFY, That I attended deceased from 8-20, 1928, to 8-21, 1928 that I last saw him alive on 8-21, 1928, and that death occurred, on the date stated above, at 6:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Intestinal Obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 8-21-28

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. O. Daniel, M. D.

, 19 (Address) Hannibal, 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: Mt. Olivet Cemetery — DATE OF BURIAL: Aug 23 1928

20. UNDERTAKER: Schwartz Funeral Home — ADDRESS: Hannibal Mo.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Marion — Registration District No. 347 — File No. 222
Township — Primary Registration District No. 3029 — Registered No.
City Hannibal (No. ... St. ... Ward)

2. FULL NAME Joseph LeRoy Jones
(a) Residence. No. ... St. ... Ward. ... (If nonresident give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.

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)

PARENTS
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 8/24 1928 C E Strode mm. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 21 1928

17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to ... 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:
Intestinal Obstruction
Several loops of ileum strangulated by band of adhesion (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) H. O. Daniel, 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

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.

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

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