EC 27

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

Do not use this space.

35912

File No. .....

Registered No. 55

1. PLACE OF DEATH

County: Jackson

Township: Washington

City: ..... (No. ....., ... St. ..... Ward)

Registration District No. 494

Primary Registration District No. 9835

2. FULL NAME John T. 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 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 Emma Jones

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 30 - 1860

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
68	1	28	

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) Ky

PARENTS

10. NAME OF FATHER Jones

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

12. MAIDEN NAME OF MOTHER Rachel Jones

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

14. INFORMANT Louisa Barber
(Address) Kansas City Mo

15. FILED 10 21, 1928 B. T. Gaines, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct - 18 - 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 - 1928, to Oct - 18 - 1928, that I last saw him alive on Oct - 14 - 1928, and that death occurred, on the date stated above, at 8:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Virginia Delirium
Pneumonia
Chronic Myocarditis

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

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. 10 mos. ..... ds.

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? Clinical & Laboratory

(Signed) B. T. Gaines, M. D.

10 21, 1928 (Address) Warrensburg 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 Dillon Mo

DATE OF BURIAL 10 21 - 1928

20. UNDERTAKER L. R. Gropp & Sons

ADDRESS Dillon 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.