JAN 21 1929

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

Do not use this space.

39467

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1. PLACE OF DEATH
County Buchanan
Township
City St. Joseph, (No. Noyes Hospital St. Ward)
Registration District No. 1001
Primary Registration District No.
File No. 1382
Registered No.

2. FULL NAME Amanda Jones,
(a) Residence. No. St., Ward. Hatfield, Missouri,
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Ulyssis S. Jones, Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR): January 1866

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
62	11	Unk.	

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

9. BIRTHPLACE (CITY OR TOWN): Nashville,
(STATE OR COUNTRY): Tennessee,

PARENTS
10. NAME OF FATHER: James Taylor,
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Unknown,
(STATE OR COUNTRY): Tennessee,
12. MAIDEN NAME OF MOTHER: Jemima Chase,
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Unknown,
(STATE OR COUNTRY): Tennessee,

14. INFORMANT: Mrs Annie Simpson
(Address): Hatfield, Missouri.

15. FILED: DEC 10 1928 John G. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec. 9th 1928

17. I HEREBY CERTIFY, That I attended deceased from 11-27-28, 19, to 12-9-, 1928, that I last saw her alive on 12-8-, 1928, and that death occurred, on the date stated above, at 4 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gall bladder disease (Infectious).
[illegible] (duration) yrs. 2 mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Eagleville, Mo.
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Paul Forgrave, M. D
12/9, 1928 (Address) St. Joseph, 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: Hatfield, Mo. via Auto
DATE OF BURIAL: Dec. 10 1928

20. UNDERTAKER: Heaton-Beyole & Bowman by J. W. Hoole.
ADDRESS: 319 S. 10 St. Funeral Home

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.

[illegible] information ab[illegible]
AUL OF [illegible]EATS in plain terms, a[illegible]

[illegible]

[illegible]

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: Buchanan — Registration District No.: 85 — File No.:
Township: — Primary Registration District No.: 1001 — Registered No.: 1382
City: St Joseph (No. ; St. Ward)

2. FULL NAME: Amanda 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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): W

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 2-6, 1929 — John G [illegible] — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 9 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:
Gall Bladder disease
Cholecystitis - Chronic
suppurative
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

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