

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

Do not use this space.

6240

1. PLACE OF BIRTH

County Henry

Registration District No. 347

Township Clinton Mo.

Primary Registration District No. 3018

City Clinton Mo.

File No. 35

Registered No. 35

St. _____ Ward _____

2. FULL NAME

(a) Residence Joseph Jones 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

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

wid

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Maragret Jones

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

Oct 26 1844

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

84

4

0

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)

Not known

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)

M W Jones
Rockville Mo

15.

FILED

19

Feb. 21 29
Dr. E. C. Peeler
per J. H.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Feb 20 19 29

17.

I HEREBY CERTIFY, That I attended deceased from Feb 3, 1929, to Feb 20, 1929, that I last saw him alive on Feb 20, 1929, and that death occurred, on the date stated above, at 1 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1371 Rubeosis
1301 Rubeosis
1101

(duration) 7 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY)

Old age

(duration) 0 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

1291 any county Feb 16 29

DATE OF DEATH

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Operation

(Signed) M. J. Stettin M. D.

, 19 (Address) Clinton 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

DATE OF BURIAL

Osceola Mo

2/21 19 29

20. UNDERTAKER

ADDRESS

Spore & Son Clinton Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

MAR 22 1929

