

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

Do not use this space.

10018

**1. PLACE OF DEATH**

County..... Cole  
Township.....  
City..... Jefferson (No.....)

Registration District No. 213  
Primary Registration District No. 3014

File No.....  
Registered No. 77  
St. .... Ward)

**2. FULL NAME** John Jones

(a) Residence. No..... St..... Ward.....  
(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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June--11--1855

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
73 9 4

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Retired 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) Decatur, Missouri

**PARENTS**  
10. NAME OF FATHER  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
12. MAIDEN NAME OF MOTHER  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT Mrs. Richard Enloe  
(Address) Jefferson City, Missouri

15. FILED 3-16 1929 L. W. Bedford REGISTRAR

**4 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar-15 1929

17. I HEREBY CERTIFY, That I attended deceased from House....., 1929, to March 10....., 1929, that I last saw him..... alive on March 11....., 1929, and that death occurred, on the date stated above, at 2 p.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

18 Terminal Pneumonia (after 194 B long suffering from Corneitis of 53 left side of neck and a fractured hip (duration) 2 yrs. mos. ds.

CONTRIBUTORY Corneitis & fractured hip (SECONDARY) (duration) 2 yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH. Jefferson City

19. DID AN OPERATION PRECEDE DEATH? No DATE OF

20. WAS THERE AN AUTOPSY? No  
WHAT TEST CONFIRMED DIAGNOSIS Clinical evidence only  
(Signed) J. S. Johnson M. D.

3/14 1929 (Address) Cent Trust Bldg

\*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 Spring Garden DATE OF BURIAL 3/17 1929

20. UNDERTAKER WYMORE-GORDON UNDERTAKING CO. ADDRESS J. G. M.

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 Cole Registration District No. 213 File No. 10018  
 Township Jefferson Primary Registration District No. 3014 Registered No. 77  
 City Jefferson (No. ....) St. .... Ward)

2. FULL NAME John 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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15 1929

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:  
Terminal pneumonia after long suffering from carcinoma of the rectum caused by falling  
Contributory carcinoma + fractured hip

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)

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**

15. FILED 3-14-29 L. W. Budzort REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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