13746

Do not use this space.

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

1. PLACE OF DEATH
County: Audrain — Registration District No. 15 — File No. 1
Township: — Primary Registration District No. 4619 — Registered No. 45
City: Martinsburg (No. ..... St. ..... Ward)

2. FULL NAME: James W 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. 8 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: Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 12 - 1867

7. AGE: Years 61 — Months — Days 21 — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): [illegible]

PARENTS
10. NAME OF FATHER: [illegible]
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): [illegible]
12. MAIDEN NAME OF MOTHER: [illegible]
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): [illegible]

14. INFORMANT: Anna Jones
(Address): Martinsburg Mo

15. FILED 4/3, 1929 USGArnold
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr 3 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 26, 1929 to Apr 3, 1929, that I last saw h[illegible] alive on Apr 3, 1929, and that death occurred, on the date stated above, at 5 30 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremia
137
1320
135
(duration) ..... yrs. ..... mos. ✓ ds.

CONTRIBUTORY (SECONDARY): Prostatic Obcus (duration) ..... yrs. ..... mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) USGArnold, M. D
4/3, 1929 (Address) Martinsburg

*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: Martinsburg Cemetery — DATE OF BURIAL: 4-6-1929

20. UNDERTAKER: [illegible] — ADDRESS: [illegible]

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.