

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

Do not use this space.

21334

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... (No.....) St..... Ward.....

Registration District No. 1159  
Primary Registration District No. 5349

File No.....  
Registered No. 10

**2. FULL NAME**

McGeehan 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 M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

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

Ellen Gill

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 26 - 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
62 6 4

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Praying Center  
(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) Ohio

10. NAME OF FATHER John Jones

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

12. MAIDEN NAME OF MOTHER Josephine Bileha

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

14. INFORMANT Ellen Jones  
(Address) Graphiteville Mo

15. FILED Aug 19 29 Amie Byrnes REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29 1929

17. I HEREBY CERTIFY, That I attended deceased from June 29 to June 29, 1929, and that I last saw him alive on June 29, 1929, and that death occurred, on the date stated above, at 9:45 A.M.

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

Angina Pectoris

(duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) 89

(duration) yrs. mos. ds.  
18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH. No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical  
(Signed) C. W. Jay M. D.

, 19 (Address) Fronton 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  
Middlebrook No 7-1 1929

20. UNDERTAKER ADDRESS  
Rayman White & Son Fronton

N. B.—Every item of information should be carefully supplied. AGE should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. 1929



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

ALL INFORMATION REQUIRED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Iron

Registration District No. 1159

File No. \_\_\_\_\_

Township 11

Primary Registration District No. 5949

Registered No. 10

City \_\_\_\_\_ (No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

**2. FULL NAME** McFerson 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 M

4. COLOR OR RACE W

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 26-1868

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>60</u>	<u>6</u>	<u>3</u>	

**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)

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 Aug 6, 19 Lewis C. Byman  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29 19 29

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:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_

DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

12221