

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

Do not use this space.

24913

1. PLACE OF DEATH

County Jackson Registration District No. 400 File No. _____
 Township Prarie Primary Registration District No. 3300D Registered No. 93
 City _____ (No. _____) St. _____ (Ward _____)

2. FULL NAME Henry Jones

(a) Residence. No. 107 Home 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Unknown
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-26-1848
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 9 19
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Laborer
 (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) Missouri

10. NAME OF FATHER John

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

12. MAIDEN NAME OF MOTHER William

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

14. INFORMANT J.W. Boatright (Address) Jackson, Mo.

15. Date July 29 1929 Registrar J.A. James

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-15 1929

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929 to 7-15, 1929 that I last saw him alive on July 15 1929, and that death occurred, on the date stated above, at 1 o'clock a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
93 P.

CONTRIBUTORY (SECONDARY) 900 (duration) _____ yrs. _____ mos. _____ da.

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) J.W. Boatright, M.D. 7/5, 1929 (Address) Independence

*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 St. Marys DATE OF BURIAL 7-18 1929

20. UNDERTAKER Ketterlin ADDRESS St. C no

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. 6 1929 48 237 31

