

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

Do not use this space.

31083

**1. PLACE OF DEATH**  
 County Jackson Registration District No. 400  
 Township Prairie Primary Registration District No. 7527  
 City Little River, Mo (No. ....) St. .... Ward)

**2. FULL NAME** William Jones  
 (a) Residence No. J. B. Stagner 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** male **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** single  
 (write the word)

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** 1847

**7. AGE** YEARS 82 MONTHS — DAYS — If LESS than 1 day, .... hrs. or .... min.

**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) unknown  
 (c) Name of employer unknown

**9. BIRTHPLACE (CITY OR TOWN)** (STATE OR COUNTRY) Mass

**10. NAME OF FATHER** unknown

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

**12. MAIDEN NAME OF MOTHER** unknown

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

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Sept 9 - 1929

**17. I HEREBY CERTIFY**, That I attended deceased from 9-7, 1929, to Sept 9, 1929, that I last saw h. unalive on, Sept 5, 1929, and that death occurred, on the date stated above, at 2 o'clock a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Acute respiratory  
97A  
102  
 (duration) 2 yrs. .... mos. .... ds.

**CONTRIBUTORY (SECONDARY)** Renality  
 (duration) 10 yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED** 8900  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
 WAS THERE AN AUTOPSY.....  
 WHAT TEST CONFIRMED DIAGNOSIS.....  
 (Signed) J. H. Cassard, M. D.  
9-9, 1929 (Address) Indep 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** Maple Hill Cemetery **DATE OF BURIAL** Sept. 10, 1929

**20. UNDERTAKER** Kelleriee **ADDRESS** R. City Mo

**14. INFORMANT** J. W. Hostetter  
 (Address) unknown, Co. House

**15. FILED** Sept 10 1929 M. James  
 REGISTRAR

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.

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