

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.

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

Do not use this space.

31709

1. PLACE OF DEATH
 County St. Clair Registration District No. 764
 Township Montgomer Springs Primary Registration District No. 6008
 City Montgomer Springs No. 4459 St. 4 Ward 4

2. FULL NAME James Albert 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 2 yrs. 0 mos. 0 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) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Minnie May Allen
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 11 - 1882
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
47 | 7 | 12 | _____ | _____ | _____
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work 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) Ky.
10. NAME OF FATHER Duff Jones
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ky.
12. MAIDEN NAME OF MOTHER Rose Jones
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ky.

14. INFORMANT Mr. A. A. Jones
 (Address) Montgomer Springs
15. FILED 9/23 29 George Alexander REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-22 1929
17. I HEREBY CERTIFY, That I attended deceased from _____
9-20 1929, to 9-22 1929
 that I last saw him alive on 9-22 1929, and that death occurred, on the date stated above, at 1:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ptomaine Poisoning
1775 1917 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) possibly eating sardines
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH... X 40
19. DID AN OPERATION PRECEDE DEATH? No DATE OF... X
20. WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Extreme Pain, protracted condition of throughout
 (Signed) J. W. Richardson M. D.
19 (Address) Giffier 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 St. Clair Cem DATE OF BURIAL 9/24 1929
20. UNDERTAKER J. B. Goodrich ADDRESS Osceola

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Handwritten mark, possibly the number '6'.

Handwritten marks and symbols, possibly including the number '10' and some illegible characters.