

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

Do not use this space.

13135

MAY 1 26 1930

**PLACE OF DEATH**

County Darke  
Township Washington  
City ..... (No. .....)

Registration District No. 449  
Primary Registration District No. 5612

File No. .....  
Registered No. 1863  
St. ..... Ward .....

2. FULL NAME Douglas 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
About 80 not known

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) Ark.  
(STATE OR COUNTRY)

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Allen Hapley  
(Address) Morgan, Mo.

15. FILED 4/26, 1930 J M Bellinger  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 25 1930

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1930, to ....., 19....., that I last saw him alive on April 16, 1930, and that death occurred, on the date stated above, at 10:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Dysentery

130 (duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) 160 (duration) yrs. mos. 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 Physical Ex  
(Signed) J. B. ... M. D.  
, 19 ..... (Address) Lebanon, 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 Cuba Cem. DATE OF BURIAL 4/26 1930

20. UNDERTAKER Balmer ADDRESS Lebanon Mo.

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.

