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

Do not use this space. 22429

1. PLACE OF DEATH
County: Franklin — Registration District No.: 283 — File No.: 112
Township: — Primary Registration District No.: 4167 — Registered No.:
City: Cardwell (No. ..., ... St. ... Ward)

2. FULL NAME: Rachel Jane Jones
(a) Residence. No. ... 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. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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: William Jones

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept 15th 1855

7. AGE: Years 75 — Months 9 — Days 20 — If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DEACESED
(a) Trade, profession, or particular kind of work: House Wife
(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): Ind

PARENTS
10. NAME OF FATHER: James Dixon.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ind
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Know

14. INFORMANT: A. Jones
(Address): Cardwell Mo.

15. FILED: 7-6, 1930 — [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 5th 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 6th, 1929, to July 5th, 1930, that I last saw h. alive on July 2nd, 1930, and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Traumatic Pancreagia
Malarial Complications
194B
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY)
(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? None
(Signed) D. A. Porter, M. D
, 19 (Address) Cardwell 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: Cardwell Cemetery — DATE OF BURIAL: July 6th 1930
20. UNDERTAKER: Howard Andrews — ADDRESS: Cardwell Mo.

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Dunklin — Registration District No. 283 — File No. 112
Township — Primary Registration District No. 4167 — Registered No.
City Cardwell (No. ..... St. ..... Ward)

2. FULL NAME Rachel Jane 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 15 - 1855

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
X	74 X	9	20	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 5 1930

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:
Traumatic Paraplegia
Malarial Complications
Don't Know Dr. D.A. Parker

(duration) ..... yrs. ..... mos. ..... ds.

UTORY
ARY)

(duration) ..... yrs. ..... mos. ..... ds.

WAS DISEASE CONTRACTED
OT AT PLACE OF DEATH?
OPERATION PRECEDE DEATH? DATE OF
ERE AN AUTOPSY?
TEST CONFIRMED DIAGNOSIS?
Signed) ....., M. D
, 19 (Address)

the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state
S AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or

OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

Please state cause of Traumatic Paraplegia. Give Kind of accident.

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15. FILED 7-6, 1930 [signature] REGISTRAR

ES UNTIL THEY ARE COMPLETE AND RESCRIBED BY LAW

S-22429