

SEP 24 1930

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

Do not use this space.

26553

1. PLACE OF DEATH

County Iron  
Township Iron  
City Bellevue (No. \_\_\_\_\_)

Registration District No. 1159  
Primary Registration District No. 5549

File No. \_\_\_\_\_  
Registered No. 18 Ward \_\_\_\_\_

2. FULL NAME Lola. Onales. Jaycox

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(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. (If nonresident, give city or town and State)

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 ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 16 1919

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
11 16

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work 105  
(b) General nature of industry, business, or establishment in which employed (or employer) 8  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Bellevue  
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Edmer Jaycox

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

12. MAIDEN NAME OF MOTHER Mary Forley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Iron, Mo  
(STATE OR COUNTRY) Missouri

14. INFORMANT S. A. Forley  
(Address) Bellevue Mo.

15. FILED 9-5-30 Levin C. Byrum REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug-23-1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 7<sup>th</sup>, 1930, to Aug 23<sup>rd</sup>, 1930 that I last saw him alive on Aug 16, 1930, and that death occurred, on the date stated above, at 4:00 p. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chl. Pneumonia  
(duration) \_\_\_\_\_ yrs. mos. 7 ds.  
CONTRIBUTORY Contributory Infestyl.  
(SECONDARY)  
Septicemia (duration) \_\_\_\_\_ yrs. mos. 16 ds.

18. WHERE WAS DISEASE CONTRACTED At home  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

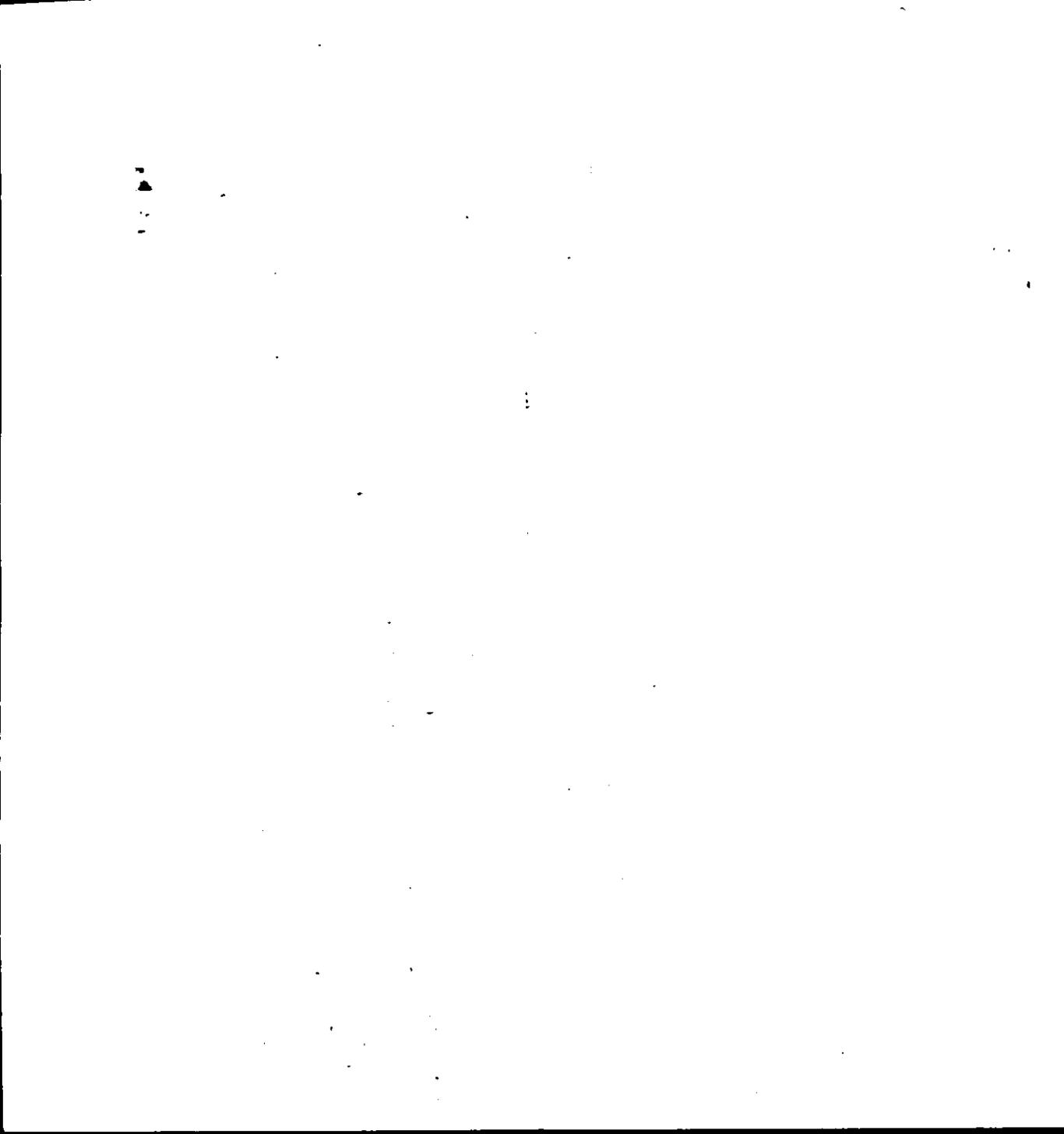
19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical  
(Signed) W. Houston M. D.  
, 19 \_\_\_\_\_ (Address) Bellevue 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 Montgomery DATE OF BURIAL Aug 27 1930

20. UNDERTAKER ✓ ADDRESS \_\_\_\_\_



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Drew Registration District No. 115-9 File No. ....  
 Township ..... Primary Registration District No. 5-5-49 Registered No. 18  
 City ..... (No. ....) St. .... Ward .....

**2. FULL NAME**

Lola Emaline Jaycox  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 7 - '29

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
11 16

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... da.  
 (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) .....

10. NAME OF FATHER .....

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

12. MAIDEN NAME OF MOTHER .....

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

14. INFORMANT (Address) .....

FILED 9-5-30 Clara B. ... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 23 1930

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at .....

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

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

, 19 (Address)

\*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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LA

SUPPLEMENTARY

S-26553