

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

Do not use this space.

38682

1. PLACE OF DEATH

County Butler
Township Poplar-Bluff
City Poplar Bluff, Mo. (No.)

Registration District No. 89
Primary Registration District No. 3027

File No.
Registered No. 238
St. Ward)

2. FULL NAME Ruby Louise Jones

(a) Residence. No. 422 Oak St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 3 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*) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 26th 1922

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hra. ormin.
8 1 15

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) St Francis, (STATE OR COUNTRY) Ark

10. NAME OF FATHER Jim Jones
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Quin (STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Edith Manship
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tany Co (STATE OR COUNTRY) Missouri

14. INFORMANT Edith Jones (Address) Poplar Bluff, Missouri

15. FILED Dec 11, 1930 B J Clump REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 11 1930

17. HERE I HEREBY CERTIFY, That I attended deceased from 8 1930 noon 30 that I last saw her alive on Nov 10 1930, and that death occurred, on the date stated above, at 1:00 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Abscess
108
114B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Pneumonia Toxar (duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED 101W
IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) Arthur J. Cowe M. D.
Well, 19 31 (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 Gravel Hill Cemetery DATE OF BURIAL Dec 12 1930

20. UNDERTAKER Greer Undertaking Co Poplar ADDRESS Bluff, Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

JAN 19 1931

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