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

Do not use this space. 37 Sagus Dr.

File No. .....
Registered No. 3

1. PLACE OF DEATH

County Greene — Registration District No. 318
Township N. Central — Primary Registration District No. 5439
City ~~Springfield~~ Mo. Rt. 4 ..... St. ..... Ward)

2. FULL NAME James Leo Jones

(a) Residence. No. Rt. 4 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)
Male	White	

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 16 1930

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	6	15	

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

9. BIRTHPLACE (CITY OR TOWN) Springfield Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER W. J. Jones
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Republic
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Viola Carrell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Taney Co.
(STATE OR COUNTRY) Mo.

14. INFORMANT W. J. Jones
(Address) Rt. 4 Springfield Mo.

15. FILED 1-2 1931 Lot Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 1 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1930, to Jan 1 1931, that I last saw him alive on Jan 1 1931, and that death occurred, on the date stated above, at 6:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1a Pneumonia Broncho
1b
1c
(duration) ....yrs. 8 mos. ....ds.

CONTRIBUTORY (SECONDARY) none
(duration) ....yrs. ....mos. ....ds.

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) G. Dayes M. D.
1-2 1931 (Address) 62 Woodruff

*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 Niva Mo. — DATE OF BURIAL Jan. 2 1931

20. UNDERTAKER Alma Lefmeyer Funeral Home — ADDRESS 534 St. Louis

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.