

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

Do not use this space.

10936

1. PLACE OF DEATH

County Madaway Registration District No. 625-
Township Patte Primary Registration District No. 3031
City Marionville St. _____ Ward _____

File No. _____
Registered No. 36
St. _____ Ward _____

2. FULL NAME

(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 male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 14

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) 237
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Indiana 2

10. NAME OF FATHER Geo H Jones

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

12. MAIDEN NAME OF MOTHER Sarah Hickman

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

14. INFORMANT Chas H Jones
(Address) Dennis Tal

15. FILED 3-31-1931 C. P. Fryer REGISTRAR
M.E.C.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 29 1931

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 head at home

THE CAUSE OF DEATH* WAS AS FOLLOWS: Arrival

Heart failure from an old myocardial
1931

(duration) 7 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? ✓ DATE OF _____

WAS THERE AN AUTOPSY? ✓

WHAT TEST CONFIRMED DIAGNOSIS Clinical

(Signed) Geo J Reed, M. D.

, 19____ (Address) Marionville 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 DATE OF BURIAL
Oak Hill Cemetery 3-31-1931

20. UNDERTAKER ADDRESS
Price Frank Marionville 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. APR 25 1931

