

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

Do not use this space.

1976

JAN 26 1934

22

1. PLACE OF DEATH

County New Madrid Co Registration District No. 604 File No. 439
Township St. Charles Primary Registration District No. 5802 Registered No. _____
City St. George (No. _____) St. _____ Ward _____

2. FULL NAME Sage 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 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 Wm Jones

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —
10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

13. NAME Dr. R. R. R. R.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) —

15. MAIDEN NAME Dr. R. R. R. R.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) —

17. INFORMANT J. M. Mason
(ADDRESS) New Madrid Co

18. BURIAL, CREMATION, OR REMOVAL
PLACE home DATE 1/18 1934

19. UNDERTAKER none
(ADDRESS)

20. FILED 1/17 1934 W. H. O'Barren
Registrar

3

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-16 1934

22. I HEREBY CERTIFY, That I attended deceased from 12-20 1933 to 1-16 1934

I last saw him alive on 1-16 1934. Death is said to have occurred on the date stated above, at 8 P. m.

The principal cause of death and related causes of importance were as follows:

Septicemia - result of sleeping very long
1530
1530
Other contributory causes of importance: Heart & lungs
Date of onset _____

Name of operator Dr. R. R. R. R. Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

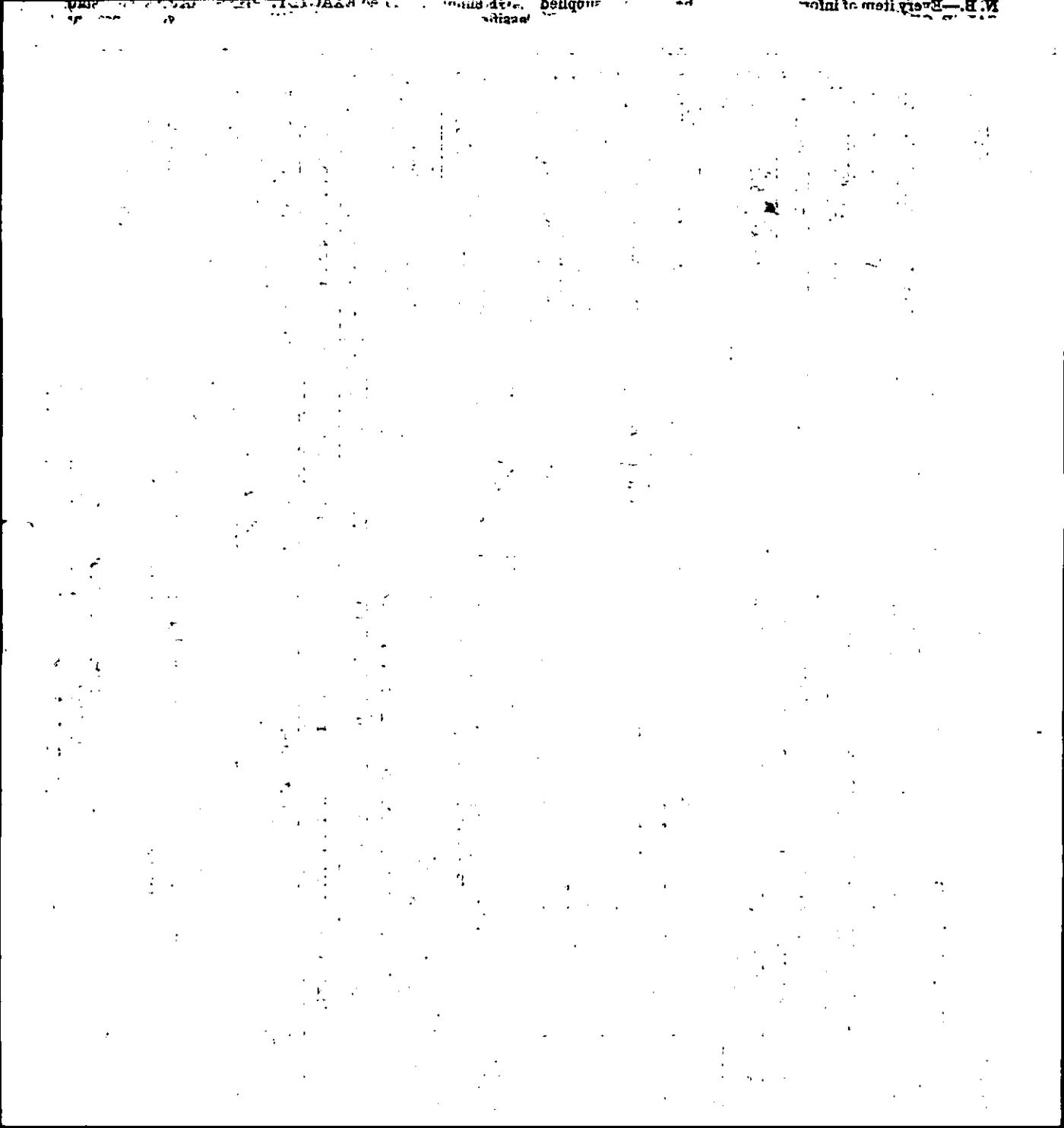
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) W. H. O'Barren, M. D.
(Address) New Madrid Co

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

X X X



**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 New Madrid Registration District No. 604
Township New Madrid Primary Registration District No. 5802
City..... (No., St. Ward)

File No. 1976
Registered No. 439

2. FULL NAME

Lizzie James
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) about 1864

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
<u>about 70</u>		<u>28</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 19 W. J. Barron Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 16, 1934

22. I HEREBY CERTIFY That I attended deceased from

....., to, 19.....

I last saw h..... alive on, 19..... Death is said

to have occurred on the day stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

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

(Address).....

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-1976