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

JUN 25 1934

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

Do not use this space.

No holdwork

File No. 17567

Registered No. 56

1. PLACE OF DEATH

County Nodaway — Registration District No. 625

Township Polk — Primary Registration District No. 5827

City ..... (No. ..... St. ..... Ward)

2. FULL NAME George Henry 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. 11 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	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-28-1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	79	6	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Galio Co.
(STATE OR COUNTRY) Ohio

PARENTS

10. NAME OF FATHER Alfred Jones

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

12. MAIDEN NAME OF MOTHER Elizabeth Neal

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

14. INFORMANT Alfred Jones
(Address) Maryville Mo.

15. FILED 5-7, 1934 Mamie E. Clardy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-6 1934

17. I HEREBY CERTIFY, That I attended deceased from Mar 15, 1934, to May 5, 1934 that I last saw him alive on May 5, 1934, and that death occurred, on the date stated above, at 6 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paralysis

131 [illegible]

[illegible] (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Nephritis

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH ✓

DID AN OPERATION PRECEDE DEATH? No DATE OF ✓

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Lab findings

(Signed) F. M. Ryan, M. D.

, 19 (Address) Maryville 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
Pickering Cemetery	5-8 1934
20. UNDERTAKER	**ADDRESS**
Campbell Funeral Home	Maryville Mo

+ M Ryan.

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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

17567

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adaway

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: George Henry Jones

Who died at _____ on May 6 - 1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W ~~Single~~, ~~married~~, widowed or ~~divorced~~: _____

Date of birth _____ Age: Years 79 Months 6 Days 8

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

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

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) Paralysis

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Nephritis [illegible]

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Other contributory causes of importance None

Name of operation ✓ Date of ✓

What test confirmed diagnosis? _____ Was there an autopsy? no

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

Accident, suicide, or homicide? No 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 _____

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

If so, specify _____

Name of physician ~~[illegible]~~ Ryan M D

Address of physician Maryville Mo

Signature of Registrar Mamie E Clardy Date filed

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh M. D.

Special Agent.

Reg. Dist. No. 625

Primary Reg. Dist. No. 5827

S-17567

S-17569