

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.

JUN 24 1935 MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

16993

1. PLACE OF DEATH

County Lafayette Registration District No. 470  
Township Madison Primary Registration District No. 5633  
City (No. ) St. Ward

File No. \_\_\_\_\_  
Registered No. 51

2. FULL NAME

Elzie Jones  
(a) Residence, No. 300 Cocoa St. Ward. Salalia Mo  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>negro</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mrs Elzie Jones</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb 15 - 1894</u>		
7. AGE YEARS <u>41</u>	MONTHS <u>3</u>	DAYS <u>9</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>coal hauler</u>		
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) <u>Dec 1934</u>		11. Total time (years) spent in this occupation <u>life</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Smithton Mo.</u>		
13. NAME <u>Ed Jones</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Syracuse Mo</u>		
15. MAIDEN NAME <u>Mary Reynolds</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Syracuse Mo</u>		
17. INFORMANT (ADDRESS) <u>deceased. Mrs. Not Vernon Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE, <u>Salalia Mo</u> , DATE <u>May 25</u> , 19 <u>35</u>		
19. UNDERTAKER (ADDRESS) <u>Phillips &amp; Fodder Not Vernon Mo.</u>		
20. FILED <u>May 25</u> , 19 <u>35</u> P. A. <u>Lobner</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 24, 1935

22. I HEREBY CERTIFY That I attended deceased from April 11, 1935, to May 24, 1935  
I last saw h.i.l., alive on May 24, 1935 Death is said to have occurred on the date stated above, at 3:00 pm.  
The principal cause of death and related causes of importance were as follows:  
Pulmonary tuberculosis Date of onset 4/1/34  
g.h.s.

Other contributory causes of importance:  
N

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Sputum 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? No  
If so, specify \_\_\_\_\_  
(Signed) J. A. Stacker M. D.  
(Address) Mount Vernon Mo

