

OCT 1 1936

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

Do not use this space.

33503

## 1. PLACE OF DEATH

County *Wright*  
Township *Van Buren*  
City *Wright* (No. *1*)Registration District No. *906*  
Primary Registration District No. *6219*File No. *44*  
Registered No. *44* St. *1* Ward)

## 2. FULL NAME

(a) Residence, No. *George Calvin Jones*  
(Usual place of abode)St. *1* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *45* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

*Male*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

*Single*

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

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

*Oct. 25 - 1875*

## 7. AGE

YEARS *60*MONTHS *9*DAYS *1*

If LESS than 1 day, ..... hrs. or ..... min.

## OCCUPATION

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

*Farmer*

## 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

*July 1936* *20*

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

*Farmville Ky*

## MOTHER FATHER 13. NAME

*Wiley Jones*

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

*Ky*

## MOTHER 15. MAIDEN NAME

*Eda Norris*

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

*Ky*

## 17. INFORMANT (ADDRESS)

*C. C. Haggard*

## 18. BURIAL, CREMATION, OR REMOVAL PLACE

*Friendship*DATE *8-27-1936*

## 19. UNDERTAKER (ADDRESS)

*Britten Funeral Home*

## 20. FILED

*g 31 36 Carolyn Collins Registrar*

## 21. DATE OF DEATH (MONTH, DAY, AND YEAR)

*Aug 26 1936*

## 22. I HEREBY CERTIFY, That I attended deceased from

*8/25 1936* to *8/26 1936*I last saw him alive on *8/25 1936*. Death is saidto have occurred on the date stated above, at *6 A.* m.

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

*Auricular Fibrillation*

Date of onset

*95a*

## Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? *clinical* 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?

If so, specify \_\_\_\_\_

(Signed) *R. A. Ryan*, M. D.(Address) *mtm Grand*

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

