

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

Do not use this space.

1. PLACE OF DEATH

County Ray Registration District No. 914
 Township Grape Grove Primary Registration District No. 6233
 City (No. _____) St. _____ Ward _____

File No. 3890
 Registered No. 2

2. FULL NAME

William Jones 520
 (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 (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July-31-1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
75 3 18

OCCUPATION
 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. laborer
 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) Ray Co Mo

FATHER
 13. NAME William Jones

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

MOTHER
 15. MAIDEN NAME Jane Silkwood

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

17. INFORMANT (ADDRESS) John Jones

18. BURIAL, CREMATION, OR REMOVAL PLACE Union point DATE Jan 20 1938

19. UNDERTAKER (ADDRESS) Jno W. Richmond

20. FILED Jan 20 1938 H E Gant Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 19 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

Cerebrally 820 Jan 19 38
 Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical History 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) H E Gant, M. D.
 (Address) Richmond, Mo.

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

RECEIVED

FEB 28 1938

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MO. STATE DEPT. OF HEALTH