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.

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

23140
Do not use this space.

REC'D JUL 25 1938

1. PLACE OF DEATH
(a) County: Texas
(b) Township: Sheppard
(c) City: Licking
Registration District No. 868
Primary Registration District No. 6149
Registered No. 20
(d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs. Ory Jones
(a) Residence, No. 520 St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: W. F. Jones
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Nov. 20, 1875
7. AGE: Years 62 Months 6 Days 16 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housework
9. Industry or business in which work was done, as saw mill, bank, etc.: House Wife
10. Date deceased last worked at this occupation (month and year): Nov 1927
11. Total time (years) spent in this occupation: 4 2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY): Not Known Wright Co. Mo

FATHER
13. NAME: Martin Long
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Not Known Ohio

MOTHER
15. MAIDEN NAME: Martha Robinson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Not Known Ohio

17. INFORMANT (ADDRESS): W. F. Jones Licking Mo
18. BURIAL, ~~CREMATION, OR REMOVAL~~ PLACE: Licking Cem. DATE: 6-7-38
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Smith & Ferguson Licking Mo
20. FILED: 6/7 1938 H. L. Reed Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): June 6, 1938
22. I HEREBY CERTIFY, That I attended deceased from May 10, 1938, to June 6, 1938
I last saw h.e. alive on June 4, 1938 Death is said to have occurred on the date stated above, at 8 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of inguinal glands and intestines	

Other contributory causes of importance: 52

Name of operation ..... 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) H. L. Reed, M. D.
(Address) Licking Mo.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

23140 -
Do not use this space.

1. PLACE OF DEATH
(a) County Texas — Registration District No. 868
(b) Township — Primary Registration District No. 6149 — Registered No.
(c) City — (d) Street No. — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Dry Jones
(a) Residence, No. — St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) M -
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS 62 MONTHS 6 DAYS 11 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL
PLACE — DATE — 19
19. FUNERAL DIRECTOR (ADDRESS)
20. FILED — 19 — *Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 6, 1938
22. I HEREBY CERTIFY, That I attended deceased from ....19.... to ....19....
I last saw h.... 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:
Carcinoma inguinal gland and intestines at first in a birth mark on outside middle part of left upper leg
Date of onset
Other contributory causes of importance:
53
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) H. L. Reed, M. D.
(Address) Licking Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, [illegible] classified. Exec. statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-23140