

667 MAR 20 1939

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

7114
Do not use this space.

1. PLACE OF DEATH

(a) County Macou Registration District No. 533
 (b) Township Macou Primary Registration District No. 3027 Registered No. 13
 (c) City Macou (d) Street No. Danmaitow Hospital 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

Walter Scott Jones
 (a) Residence, No. 1000 Cambridge, Mo. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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) Dec. 28, 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
65 1 15

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 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) July 1, 1935 11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Cambria, Mo.

FATHER 13. NAME William T. Jones 0
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wales 4

MOTHER 15. MAIDEN NAME Margaret Howard 4
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wales

17. INFORMANT (ADDRESS) Edwin Jones
New Cambria, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE New Cambria DATE Feb. 15, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. E. Tilleland
New Cambria, Mo.

20. FILED 2/14, 1939 Seata Tetterton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 13, 1939

22. I HEREBY CERTIFY That I attended deceased from March, 1936 to Feb. 13, 1939
 I last saw him alive on Feb. 12, 1939. Death is said to have occurred on the date stated above, at 6:35 P.M.

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

Myocarditis (chronic) Arteriosclerosis
 Date of onset 3 yrs. or more

Other contributory causes of importance:

Bronchial asthma Bronchiectasis
3 or more yrs.

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? No
 If so, specify _____ (Signed) J. P. Morrow, M. D.

(Address) Macou, Mo.

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.

RECEIVED

District Health Officer No. 10

District File Number 10-34-353

Date Filed MAR 14 1939

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,

H. J. Gilleland

, or by

Registered Apprentice No., working under my personal supervision.

Signed

H. J. Gilleland

Licensed Embalmer No. 4019

P. O. Address New Cambria, Mo.

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

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