

REC'D JUN 8 1939

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

18628  
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318  
(b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 399  
(c) City SPRINGFIELD (d) Street No. 1121 Rosshoke 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

(a) Residence, No. 1121 Rosshoke St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Alice  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 14, 1871  
7. AGE YEARS 67 MONTHS 10 DAYS 27 If LESS than 1 day, ..... hrs. or ..... min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Ret. Merchant  
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) Springfield, Mo.  
13. NAME Fidelis S. Jones  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va.  
15. MAIDEN NAME Sarah Hackney  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) U. Va.  
17. INFORMANT Mary Alice Jones (ADDRESS) Springfield, Mo.  
18. BURIAL, CREMATION, OR REBURYAL PLACE Wright DATE May 13 39  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alma Schreyer Springfield, Mo.  
20. FILED 5-13-39 Chas. A. George Mo. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 11, 1939  
22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1936 to May 11, 1939  
I last saw h. live alive on May 11, 1939.. Death is said to have occurred on the date stated above, at 6 P. m.  
The principal cause of death and related causes of importance were as follows:  
Hypertensive myocardial insufficiency Date of onset 6-1-38  
Other contributory causes of importance: Paralysis 1-1-26  
Name of operation 0 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) Reuben R. Webster M. D.  
Address Springfield, Mo.

K. 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.

9322

**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 comply with the above constitutes grounds for revocation of license.)**

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

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.....

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

18628  
Do not use this space.

1. PLACE OF DEATH  
(a) County Greene Registration District No. 318  
(b) Township Springfield Primary Registration District No. 2001  
(c) City Springfield (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 Charles P. Jones  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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 MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
67 10 27

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

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

MOTHER 15. MAIDEN NAME

MOTHER 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-11-1939

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:

Hypertensive Map. Cardial Insufficiency 82%

Other contributory causes of importance:

Hemiplegia Cerebral Hemorrhage

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) Leslie R. Sweet, M. D.  
(Address) Springfield Mo

Local Registrar.

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

