

REC'D AUG 7 1939

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

27095  
Do not use this space.

1. PLACE OF DEATH  
(a) County Clayton Registration District No. 875  
(b) Township \_\_\_\_\_ Primary Registration District No. 3039 Registered No. 187  
(c) City or Nevada (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. mo. da. (f) How long in U. S., if of foreign birth? yrs. mo. da.

2. PRINT FULL NAME Malinda Bell Jones  
(a) Residence, No. 715 N. Adams St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 W. H. Jones

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 1, 1880

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, .....hrs. or .....min.
	<u>59</u>	<u>5</u>	<u>18</u>	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. house keeper

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) Terryville Ky.

FATHER 13. NAME William May

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT Mary Jones  
(ADDRESS) Nevada Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Mount St. Park DATE 7/23, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Reibinger  
Nevada Mo.

20. FILED 7/22, 1939 Allen W. Hays  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 19, 1939

22. I HEREBY CERTIFY, that I attended deceased from June 2, 1939, to July 19, 1939, I last saw her alive on July 19, 1939 Death is said to have occurred on the date stated above, at 10 P. m.  
The principal cause of death and related causes of importance were as follows:  
Cerebral Hemorrhage

Other contributory causes of importance:  
Sciatic Neuritis  
Fracture Rt Hip

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? Exam 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) W. R. Love, M. D.  
715 (Address) Nevada, Mo.

Date of onset July 19, 1939  
Dont know July 18/39

1946

RECEIVED  
District Health Officer No.  
District File Number 7-39-11  
Date Filed 8-4-39

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 *Marsh Bechinga*  
Licensed Embalmer No. *26156*  
P. O. Address *Nevada, Mu*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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

27095-

Do not use this space.

1. PLACE OF DEATH

(a) County Vernon Registration District No. 875  
 (b) Township..... Primary Registration District No. 3039 Registered No.....  
 (c) City Nevada (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 Mahinda Bell 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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.  
39 5 18

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) 7-19, 1939

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

Cerebral Hemorrhage  
1810  
 Date of onset  
 Other contributory causes of importance:  
acute hepatitis  
fracture Rt. Hip

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? accident Date of injury 7-18, 1939

Where did injury occur? at home (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

she fell trying to get out of bath tub into a chair without reaching for assistance  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify

(Signed) W. S. Love, M. D.

(Address) Nevada mo.

SUPPLEMENTARY

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

1939  
S-27095