SEP 12 1939

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

29185
Do not use this space.

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.

37 3 6

1. PLACE OF DEATH
(a) County Greene / Registration District No. 318
(b) Township or / Primary Registration District No. 2001 Registered No. 671
(c) City (d) Street No. Springfield Baptist 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 Winnie Jones.
(a) Residence, No. 520 Clever, Mo St. Clever, Mo.
(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: female
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: John H. Jones

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Dec. 6-1887

7. AGE ✓

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
51	8	24	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: housewife
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): Mo.

FATHER
13. NAME: C. B. Meritt
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Tenn.

MOTHER
15. MAIDEN NAME: Sarah Wise
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo.

17. INFORMANT (ADDRESS): J. H. Jones Clever - Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Delaware DATE: Aug. 31. 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS): J. H. Maples Clever. Mo.

20. FILED: Aug 30 1939 Chas A. Gray M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Aug. 30 - 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1939, to Aug 30, 1939. I last saw h alive on Aug 30, 1939. Death is said to have occurred on the date stated above, at 2-10 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Valvular Heart Disease	1929
9 2 u	
Other contributory causes of importance:	
Hypostatic bronchopneumonia	8/28/39

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? No
If so, specify
(Signed) Robert Glenn, M. D.
(Address) Springfield

(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 J. H. Maples

Licensed Embalmer No. 2985

P. O. Address Clever. Mo.

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

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