

Registration District No. 500

Primary Registration District No. 4303

Registrar's No.

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Laclede  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community Her life time (Specify whether years, months or days)

3. (a) PRINT FULL NAME Hortense Maria Jones

3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife May Jones 6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased March 10 1860  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	79	5	5	hr. min.

9. Birthplace Linn Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business at home

12. Name J.C. Carothers

13. Birthplace Penn.  
(City, town, or county) (State or foreign country)

14. Maiden name LOMAX

15. Birthplace Penn  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Karl Jones  
(b) Address Laclede, Mo.

17. (a) Burial (b) Date thereof 8- -1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laclede, Mo.

18. (a) Signature of funeral director [Signature]  
(b) Address Laclede, Mo.

19. (a) Aug 16-39 (b) Geo O Plouffe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State S (b) County  
(c) City or town [Signature]  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A? years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15  
year 1939 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from Jan 3, 1937 to Aug 15, 1939;  
that I last saw her alive on Aug 15, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis

Due to Atherosclerosis + Myocardial Degeneration

Other conditions Diabetes  
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature [Signature] (M. D. or other)  
Address Brookfield Mo Date signed 8-15-39

Duration

2 days

10 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically

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

City Health Officer No. 11,

File Number

939-1123

SEP 5 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, or by Me

W.G. Thorne

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_



Licensed Embalmer No. 2876

P. O. Address Laclede, 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.