

N. B.—Every item of information should be carefully supplied. Age cannot be stated in terms of years and months only. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

REC'D SEP 15 1939

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

Summary
 20422
 Do not use this space.

1. PLACE OF DEATH

(a) County Pettis Registration District No. 670
 (b) Township Heath Creek Primary Registration District No. 5896 Registered No. _____
 (c) City Beaman Mo. (d) Street No. RFD # 1. _____ 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 520 Horace Jones

(a) Residence, No. Beaman Mo. RFD # 1. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 22, 1939 19

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Clara Jones

22. I HEREBY CERTIFY That I attended deceased from June 1939, to July 22, 1939
 I last saw him alive on July 10, 1939. 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:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 25, 1864

Cardio Nephritis

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

75 1 27

Liver Enlarged

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)
 11. Total time (years) spent in this occupation

Date of onset
 Other contributory causes of importance: ASB

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Edwardport Ind.

FATHER 13. NAME Thomas C. Jones

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

MOTHER 15. MAIDEN NAME Sarah Jane Wherley

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

17. INFORMANT (ADDRESS) Oleah Jones Beaman Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Union Cem. DATE July 23, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gillespie Funeral Home Sedalia, Mo.

20. FILED Aug 31, 1939 Flossie Ferguson Local Registrar.

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) O. S. Cravely, M. D.

(Address) Sedalia, Mo.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9/12/39

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,

..... Geo. Dillard, or by

Registered Apprentice No., working under my personal supervision.

Signed Geo. Dillard

Licensed Embalmer No. 3868

P. O. Address Sedalia, 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.