WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

35555
Do not use this space.

85

1. PLACE OF DEATH
(a) County Buchanan / Registration District No. 1001
(b) Township or City St Joseph / Primary Registration District No. 1001 Registered No. 1074
(c) (d) Street No. St Joseph Hosp. 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 Robert Elliott Jones
(a) Residence, No. St Joseph Hosptl St. Dearborn 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): July 21-1917
7. AGE: YEARS 22 MONTHS 2 DAYS 27 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Former
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): Dearborn Missouri O

FATHER
13. NAME: Robert Jones O
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Dearborn Missouri O

MOTHER
15. MAIDEN NAME: Grace Elliott
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Platte Co. Missouri

17. INFORMANT (ADDRESS): Robert Jones Dearborn Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE: Davis Chapel DATE: Oct 20-1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Lucian Davis Dearborn Mo.
20. FILED: Oct 19 1939 H. J. Nestlebush Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Oct 18th 1939
22. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1939, to Oct. 18, 1939
I last saw him alive on Oct. 18, 1939. Death is said to have occurred on the date stated above, at 4 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Laceration of Brain	Oct 15, 39

Other contributory causes of importance:
Fractured Skull — Oct. 15, 39
Multiple Contusions
Abrasions & Lacerations of Head & Body
Name of operation none Date of
What test confirmed diagnosis? Obs. Exam Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 10/15 1939
Where did injury occur? Faucett, Mo. (Buchanan)
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. On High way 71 (US 71)
Manner of injury Auto mobile accident
Nature of injury Fractured Skull - Lacerated Brain

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) F. G. Thompson Jr., M. D.
(Address) 825 Charles St Joseph, Mo

(Licensed Embalmer's Statement on Reverse Side)

2/10 m 9

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 Lucian Davis

Licensed Embalmer No. 1714

P. O. Address Dearborn 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.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sta[illegible]
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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

35-5-33
1074
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan — Registration District No. 85
(b) Township — Primary Registration District No. 1001 — Registered No.
(c) City St Joseph — (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 Robert Elliott Jones
(a) Residence, No. ..... St. ☐ .....
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	W	S

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.
22	2	27	

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 10/19 1939 A. J. Hettebrand
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 18 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:

	Date of onset
Laceration of Brain	
Auto + horse - 2/18/39	

Other contributory causes of importance:
Fract skull multiple contusions

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external cause (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 Auto accident
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) F. G. Thompson, M. D.
(Address) [illegible] St Joseph Mo

SUPPLEMENTARY

Also run into a [illegible] Highway

5-35555