

DEC 15 1939

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 833

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution: 904 St. Louis St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days 530

3. (a) PRINT FULL NAME NANCY LORENE 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 Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 17 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 0 hr. 0 min.

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

10. Usual occupation in home

11. Industry or business _____

12. Name Arch M. Jones

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

14. Maiden name Grace Credlow

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

16. (a) Informant's own signature Arch M. Jones

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Nov. 18-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director J. W. Lingner, Inc.

(b) Address Springfield, Mo.

19. Nov 18 1939 (b) Christl George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 904 St. Louis St
(If rural, give location)
(e) If foreign born, how long in U. S. & I. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 17
year 1939 hour 11:20 am 11 minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____ 19____, to _____ 19____;
that I last saw _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Still born Duration _____

Due to _____

Due to _____

Other conditions: _____
(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 J. E. Aldred (M. D. or other) _____

Address Springfield Date signed 11/17/39

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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

X