

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

40201
Do not use this space.

REC'D DEC 18 1939

1. PLACE OF DEATH
 (a) County Macon Registration District No. 5-31
 (b) Township Valley Primary Registration District No. 5-722B Registered No. _____
 (c) City New Columbia (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 53 1/2 Sarah Pauline Jones
 (a) Residence, No. _____ 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

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

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Prosser Ray Jones

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 15, 1906

7. AGE YEARS MONTHS DAYS 33 If LESS than 1 day, _____ hrs. or _____ min.

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 _____

FATHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Callao, Mo.
 13. NAME Arthur Grimshaw
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Callao, Mo.

MOTHER 15. MAIDEN NAME Ella Jane Dunseith
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scioto County Ohio

17. INFORMANT (ADDRESS) Prosser Ray Jones
 18. BURIAL, CREMATION, OR REMOVAL PLACE New Columbia DATE Oct 17, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Howard G. Gelland New Columbia, Mo.
 20. FILED 10/16 1939 J. A. Shacklett Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/15/1939

22. I HEREBY CERTIFY, That I attended deceased from Martha, 1939, to Oct 15, 1939
 I last saw her alive on Oct 14, 1939. Death is said to have occurred on the date stated above, at 6:00 p. m.
 The principal cause of death and related causes of importance were as follows:
Multifocal metastatic carcinoma of ovary.
Ascites

Other contributory causes of importance: 1284

Name of operation Surgical Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? no

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) A. E. Neuden, M. D.
 (Address) Callao, Mo.

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

District Health Officer No. 10

District File Number.....

Date Filed DEC. 18 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,

Howard J. Gilleland

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Howard J. Gilleland

Licensed Embalmer No. 4019

P. O. Address New Cambria

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 531
(b) Township Valley Primary Registration District No. 8722 B
(c) City..... (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 Sarah Pauline Jones

(a) Residence, No. (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-15-1906

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>33</u>	<u>3</u>		

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 1-16-1940 J. G. Shacklett Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-15-1937

22. I HEREBY CERTIFY, That I attended deceased from 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

Other contributory causes of importance:

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) A. L. Duden, M. D.

(Address) Callas

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

