

JAN 8 1940

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

43231  
Do not use this space.

1. PLACE OF DEATH

(a) County DeKalb Registration District No. 259  
 (b) Township Camden Primary Registration District No. 4158  
 (c) City Maysville (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 520 Charles Nelson 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 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) May 29 1877  
 7. AGE YEARS 62 MONTHS 7 DAYS 0 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Butcher  
 9. Industry or business in which work was done, as saw mill, bank, etc. Meat Market  
 10. Date deceased last worked at this occupation (month and year) Dec. 29-1939 11. Total time (years) spent in this occupation 20yr

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec-29-1939

22. I HEREBY CERTIFY, That I attended deceased from 12-29, 1939 to 12-29, 1939  
 I last saw h. in alive on 12-29, 1939. Death is said to have occurred on the date stated above, at 4:30 p.m.  
 The principal cause of death and related causes of importance were as follows:

Coronary thrombosis with occlusion  
Acute circulatory collapse  
 Date of onset 12-29-39  
12-29-39

Other contributory causes of importance:  
PHB

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? No  
 If so, specify \_\_\_\_\_  
 (Signed) John M. Cooper M. D.  
 (Address) Maysville, Mo.

12. BIRTHPLACE (CITY OR TOWN) Maysville, Mo. (STATE OR COUNTRY)

FATHER 13. NAME Middleton N. Jones

14. BIRTHPLACE (CITY OR TOWN) Parkville, Mo. (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Emma F. Barnett

16. BIRTHPLACE (CITY OR TOWN) Xenia, Ill. (STATE OR COUNTRY)

17. INFORMANT Edna F. Pollard (ADDRESS) Maysville Mo

18. BURIAL, CREMATION, OR REMOVAL Oak Lawn, Maysville DATE 12/31-39

19. FUNERAL DIRECTOR (NAME) U. G. Pilcher (ADDRESS) Maysville Mo.

20. FILED 1-3 1940 Ethel H. Blower Local Registrar

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.

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**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. 1932

P. O. Address Maple 710

**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.**