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 importan

JAN 10 1940

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

44924
Do not use this space.

1. PLACE OF DEATH
(a) County Vernon 3 Registration District No. 875
(b) Township Washington 1 Primary Registration District No. 6162 Registered No. 303
or
(c) City Nevada (d) Street No. State Hospital #3 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 William Robert Jones
(a) Residence, No. Carthage Mo 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 M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Addie Jones
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 27-1939
7. AGE YEARS 62 MONTHS 8 DAYS 29 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer and
9. Industry or business in which work was done, as saw mill, bank, etc. Laborer
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) Illinois 1

FATHER
13. NAME Waterman Jones 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown 9

MOTHER
15. MAIDEN NAME Alice Church
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Hospital Records

18. BURIAL, CREMATION, OR REMOVAL
PLACE Carthage Mo DATE Dec 18 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Eichinger Funeral Home Nevada, Mo.

20. FILED Dec 15 1939 Allen V. Hays Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-15, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1939, to Dec 15, 1939
I last saw him alive on 12-14, 1939. Death is said to have occurred on the date stated above, at 12:00 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lucke Meningo-encephalitis	?

Other contributory causes of importance: 34

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... 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? .....
If so, specify .....
(Signed) L. Young M. D.
(Address) State Hospital #3 Nevada Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 1-40-41
Date Filed 1-9-40

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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

44924
Do not use this space.

1. PLACE OF DEATH
(a) County Vernon
(b) Township Washington
Registration District No. 875
Primary Registration District No. 6162
Registered No. 903
(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 William Robert 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: M
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 Mar 16 1877

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 2 1939

7. AGE: YEARS 62 | MONTHS 8 | DAYS 29 | If LESS than 1 day, ... hrs. or ..... min.

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 ..... 19.... ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-15-, 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

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) J. C. ....., M. D.
(Address) .....

SUPPLEMENTARY

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

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

S-44924

1. PLACE OF DEATH

(a) County .....

(b) Township .....

(c) City .....

(c) Length of residence in city or town where death c

2. PRINT FULL NAME .....

(a) Residence, No. .....
(Usual place of abode, if no street addres

PERSONAL AND STATISTICAL PARTICULA

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOW. DIVORCED (write the word)

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.

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 ..... 19 ....

Local Registrar.

Other contribut

Name of operation .....

What test confirmed diagn

23. If death was due to ex

Accident, suicide, or homici

Where did injury occur? ...

Specify whether injury occ

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any

If so, specify .....

(Signed) .....

(Address) .....

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.