

FILED MAR 11 1940

Registration District No. **89**

Primary Registration District No. **1001**

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Saint Joseph's Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 6 months, 2 days, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan
(c) City or town Saint Joseph,
(If outside city or town limits, write "RURAL")
(d) Street No. 211 South 14th. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Donald Nicholas Jones,

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 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 August 17th, 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 6 2 hr. min.

9. Birthplace Saint Joseph, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Child,

11. Industry or business _____

12. Name Nicholas Jones,
13. Birthplace Greece,
(City, town, or county) (State or foreign country)
14. Maiden name Gladys Lowry,
15. Birthplace Maryville, Missouri,
(City, town, or county) (State or foreign country)

16. (a) Informant Nicholas Jones
(b) Address 211 So. 14th. Str.

17. (a) Burial (b) Date thereof Feb. 21, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Boonway Funeral
(b) Address 319 So. 10th. Str.

19. (a) Feb 21, 1940 (b) H. J. Neese
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb'y, day 19th.
year 1940 hour 3:00 minute 30 P.M.

21. I hereby certify that I attended the deceased from 2-19-40
_____, 19____, to 2-19-40, 19____
that I last saw him alive on 2-19-40, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia bilat. bronch. 3d

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 H. E. Petersen (M. D. or other) _____

Address 706 Franklin Date signed 2-20-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1072

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH

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 *Wm B Summerfield*

Licensed Embalmer No. *3067*

P. O. Address *312801 St Joseph Ave*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3994
Registrar's No. 195

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 85-

Primary Registration District No. 1001

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD.

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(c) Name of hospital or institution:
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME

Donald Nicholas Jones

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 2 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 4/11/40 (b) H. E. Nestlebank (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 19 year 1940 hour _____ minute _____ M.

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

Immediate cause of death Pneumonia Bilob. Bronch

Due to NO complications

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 H. E. Petersen (M. D. or other)

Address St Joseph Mo Date signed _____

Duration 3 d
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

