DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6166

Registration District No. 12d Primary Registration District No. 3009 Registrar's No. 49

1. PLACE OF DEATH:

(a) County: Cape Girardeau

(b) City or town: Cape Girardeau, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1, Hour (Specify whether years, months or days)
In this community: 1 hr.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Scott

(c) City or town: Morley Rfd #1
(If outside city or town limits, write "RURAL")

(d) Street No.: 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Effie Edna Jones 5 20

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: Married

6. (b) Name of husband or wife: Fee Gregory Jones 6. (c) Age of husband or wife if alive: 32 years

7. Birth date of deceased: August (Month) 3 (Day) 1911 (Year)

8. AGE: Years 28 | Months 5 | Days 29 | If less than one day: ____ hr. ____ min.

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

10. Usual occupation: Domestic

11. Industry or business: -

FATHER
12. Name: Andrew Price
13. Birthplace: Winfield (City, town, or county) Ala (State or foreign country)

MOTHER
14. Maiden name: Elizabeth Lambert
15. Birthplace: Winfield (City, town, or county) Ala (State or foreign country)

16. (a) Informant's own signature: Fee Gregory Jones
(b) Address: Morley, Mo. Rfd #1

17. (a) Burial, Mo. (Burial, cremation, or removal) (b) Date thereof: Feb 3 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Carpenter, McMullin, Mo.

18. (a) Signature of funeral director: John Cleston
(b) Address: Kirkegton, Mo.

19. (a) 2-2-40 (Date received local registrar) (b) J. M. Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2 year 1940 hour 11:00 minute ____ M.

21. I hereby certify that I attended the deceased from 2/2, 1940, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Eclampsia	
Due to: Pregnancy	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: ____
Of autopsy: ____

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? ____ (Specify type of place)
(e) While at work? ____ (f) Means of injury: ____

23. Signature: C. L. Duvall (M. D. or other)
Address: Cape Girardeau Date signed: 2/4/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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 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 me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed John Alvitton

Licensed Embalmer No. 2941

P. O. Address Sikeston Mo

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.

No. 2B
-2-21-40
x1 X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 06166

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 49-

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Gir- (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Francis Hosp- (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 Effie E. Jones-

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

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

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

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

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

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

10. Usual occupation .....

11. Industry or business .....

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

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) (State or foreign country)

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

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

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

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 2-40
year ..... hour ..... minute ..... M.

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

	Duration
Immediate cause of death Eclampsia	
Due to	
Due to Pregnancy- 14 6	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations Died B4 Delivery (Post-Mortem Cesarean Section)
Of autopsy

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature A. L. Fuerth (M. D. or other)
Address Cape Gir- Date signed .....