

FILED MAR 12 1940

Registration District No. **468**

Primary Registration District No. **5629**

Registrar's No. **7**

1. PLACE OF DEATH:

(a) County **Lawrence, Bank Prairie**
(b) City or town **Marionville, Mo. R.T.A.**
(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 **50 years** years, months or days)

3. (a) PRINT FULL NAME **James Luther Jones**

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

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Martha M Jones** 6. (c) Age of husband or wife if alive **29** years

7. Birth date of deceased **Jan 5 1858** (Month) (Day) (Year)

8. AGE: Years **82** Months **1** Days **23** If less than one day _____ hr. _____ min.

9. Birthplace **Greene Co Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Isaac Newton Jones**

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

14. Maiden name **Martha M. Clark**

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

16. (a) Informant **Joshua Jones**

(b) Address **Marionville, Mo**

17. (a) **Burial** (b) Date thereof **Feb 29 1940** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Marionville**

18. (a) Signature of funeral director **Bradford Funeral Home**
(b) Address **Marionville, Mo**
19. (a) **Feb 29 1940** (b) **Laura O. Canaday** (Date received local registrar) (Registrar's signature)

12. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lawrence**
(c) City or town **Rural**
(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **28** year **1940** hour **4** minute **a.m.**

21. I hereby certify that I attended the deceased from **Feb. 16, 1940** to **Feb. 28, 1940** that I last saw him alive on **Feb 27, 1940** and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia / acute nephritis**

Due to _____

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 **Wayne M. Weaver** M. D. or other **3**
Address **Marionville, Mo** Date signed **2/28/40**

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number 340-795

Date Filed MAR 11 1940

189

MAR 11 1940

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 Hiram Bradford

Licensed Embalmer No. 1305

P. O. Address Warrenville

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. 71687

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 468

Primary Registration District No. 5629

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Quack Prairie
(If outside city or town limits, write "RURAL" and name of township)
(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

James Luther 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 _____ year
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 1 23 _____ 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) _____ (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28
year 1970 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 Wesley's disease respiratory
Duration _____
Due to Do not know unless from severity.
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 130

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) _____ (c) Means of injury _____

23. Signature Wayne Weaver _____ (other) _____

Address Trassonville, Ind _____ Date signed _____

SUPPLEMENTAL

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-7168