

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

7422

State File No. \_\_\_\_\_

Registration District No. 1051

Primary Registration District No. 5768

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Mississippi  
(b) City or town Rural  
(c) Name of hospital or institution: Doune  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 3 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Mississippi  
(c) City or town Rural, 15 miles S.E. of Paris  
(d) Street No. \_\_\_\_\_  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME SAMUEL JACKSON JONES  
3. (b) If veteran, name war V 3. (c) Social Security No. 524

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar. day 4  
year 1940 hour 5 minute P. M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Flora Jones 6. (c) Age of husband or wife if alive 58 years  
7. Birth date of deceased Jan - 10 - 1873  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from View Inquest 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 Isch. femoral artery  
1st. had heart trouble  
mitral insufficiency  
Due to died suddenly  
Due to \_\_\_\_\_

8. AGE: Years 65 Months 1 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (include pregnancy within 3 months of death) AJW  
Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: View Inquest

9. Birthplace Penn. City, town, or county \_\_\_\_\_ (State or foreign country)  
10. Usual occupation Farming  
11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name Unknown 9  
13. Birthplace Unknown (City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown (City, town, or county) (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant's own signature Heaster Graft  
(b) Address St. Louis, Mo.  
17. (a) Burial (b) Date thereof May 5, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Waverly, Penn.  
18. (a) Signature of funeral director Thomas J. Kelly  
(b) Address East Prairie, Mo.  
19. (a) 3-11-40 (b) Wm. Robert Graft  
(Date received local registrar) (Registrar's signature)

23. Signature Frank E. Wagoner (M. D. or other) Coroner  
Address Charleston, Mo. Date signed \_\_\_\_\_

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.....

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

working under my personal supervision.

Signed *Travis Shelby* .....

Licensed Embalmer No. *2726* .....

P. O. Address *East Prairie, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7422

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 105-1

Primary Registration District No. 5768

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Mass  
(b) City or town James Beason  
(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)

3. (a) PRIN FULL Samuel Jackson Jones  
(b) If veteran, name war \_\_\_\_\_ (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 Jan 10 1875  
(Month) (Day) (Year)

8. AGE: Years 65 Months 1 Days 24 If less than one day \_\_\_\_\_ 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) 9-3-40 (b) Mrs Dallas Rowe  
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 4  
year 1940 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.

Immediate cause of death \_\_\_\_\_

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 Francis E. Vernon (M. D. or other) \_\_\_\_\_  
Address Charleston Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

