

Registration District No. 689 Primary Registration District No. 3033 Registrar's No.

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Louisiana Mo
(c) Name of hospital or institution:
510 SOUTH 5TH ST
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 years, months or days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Grant Jones 520
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 widowed
6. (b) Name of husband or wife Susie Jones
6. (c) Age of husband or wife if alive dead years
7. Birth date of deceased APRIL 13 1862
(Month) (Day) (Year)

8. AGE: Years 77 Months 10 Days 13 If less than one day hr. min.

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

10. Usual occupation Retired Rail Road Man

11. Industry or business
MOTHER FATHER { 12. Name Samuel Jones
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Abigail Miller
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Tommy Jones
(b) Address Louisiana Mo

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

(c) Place: burial or cremation Clarksville Mo

18. (a) Signature of funeral director H. F. Susie
(b) Address Louisiana Mo

19. (a) 2-27-40 (b) H. Haley Jr
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Pike
(c) City or town Louisiana Mo
(If outside city or town limits, write "RURAL")
(d) Street No 0 #510 South 5th St
(If rural, give location)
(e) If foreign born, how long in U. S. A? - years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. 26, day 1940
year 1940 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from Feb 20, 1940, to Feb 26, 1940
that I last saw him alive on Feb 26, 1940, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus Duration ?

Due to Carcinoma of Stomach
Due to and pancreas

Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations X
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?

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

23. Signature H. H. Redrae MD (M.D. or other)
Address Louisiana, Mo. Date signed 2/27/40

MARGIN RESERVED FOR BINDING
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

46

RECEIVED

District Health Officer No. 10

District File Number 3-40-505

Date Filed MAR 5 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.....

Harold Garner, Registered Apprentice No.
working under my personal supervision.

Signed Harold Garner

Licensed Embalmer No. 3720

P. O. Address Louisiana 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. **7780**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **689**

Primary Registration District No. **3033**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Orleans**
(b) City or town **Louisiana**
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME **Grant 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 **wid**

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
	77	10	13	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 hereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

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

19. (a) _____ (b) _____ (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 **Feb** day **26** 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 **Diabetes Mellitus**

Due to **Carcinoma of Stomach and pancreas**

Other conditions _____ (include pregnancy within _____ months of death)
Primary seat of malignancy probably in liver

Major findings: **fracturing from R. tubercular abscess (moderate) light stools) absent jaundice**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicidal death _____ during _____ period of death.
(b) Date of occurrence _____ observation prior to death.
(c) Where did _____ (County) (State) _____ autopsy not available
(d) Did injury occur in or about home, on farm, industrial place, or public place? _____

While at work? _____ (Specify type of job) _____ (e) Means of injury **falling**

23. Signature **R. L. Andrac, M.D.** (M. D. or other) _____ Address **Louisiana** Date signed _____

SUPPLEMENTARY 46

Robert L. Andrac, M.D.
216 Georgia Street
Louisiana, Missouri

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

