

FILED MAR 14 1940

930

Primary Registration District No.

5-962

Registrar's No.

1. PLACE OF DEATH:

(a) County Ralls
(b) City or town Rural, Saline Township
(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 _____
In this community 76 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ralls
(c) City or town Rural
(If outside city or town limit, write "RURAL")
(d) Street No. Saline Township; Ralls CO
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Dawley Jane Jones

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 Widowed

6. (b) Name of husband or wife William Jones 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 19th 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 8 2 hr. min.

9. Birthplace Ralls, Co. Mo. (State or foreign country)

10. Usual occupation Housekeeping

11. Industry or business Housekeeper

12. Name Robert Rouse

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

14. Maiden name Elizabeth Scobee

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

16. (a) Informant Lena Perry

(b) Address Marion City, Mo.

17. (a) Burial (b) Date thereof Feb 23; 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation De Moss Chapel

18. (a) Signature of funeral director Wilson & Son

(b) Address Marion City, Mo.

19. (a) 2-23-40 (b) J. S. Floyd
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 21 year 1940 hour 2 minute 05 P. M.

21. I hereby certify that I attended the deceased from May 35 to Feb 21 1940 that I last saw her alive on July 1 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Arterio Sclerosis Duration 1938

Due to _____
Due to _____

Other conditions CHRONIC ARTHRITIS
(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?

23. Signature John H. Webb (M. D. 1)
Address Marion City, Mo. Date signed 2-23-40

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

87

RECEIVED

District Health Officer No. 10

District File Number 3-40-523

Date Filed MAR 8 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 Lester L. Wilson

Licensed Embalmer No. 3014

P. O. Address Manassas City 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. **7853-**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **103b**

Primary Registration District No. **3962**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Ralls**

(b) City or town **Saline Sea**
(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 **Dawley Jane Jones**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **♀** 5. Color of hair **w**

6. (a) Single, widowed, married, divorced **wid**

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 **76** Months **8** Days **2** If less than one year _____ min.

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

10. Usual occupation **House keeper**

11. Industry or business **House keeper**

MOTHER FATHER

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)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **2-23rd 1940** (b) **J. E. Floyd**
(Date received local registrar) (Registrar's signature)
by wife

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 **2** day **21**
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
that last saw him 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 _____

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) _____ (Means of injury)

23. Signature **John N. Hibbs** (Mr. D. or other)
Address **Bronaue City** Date signed _____

STUPIDLY MISAPPLIED

