

FILED MAR 12 1940

Registration District No. 737

Primary Registration District No. 5973

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Randolph
 (b) City or town Silvercreek Rural
 (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 2
 (Specify whether
 In this community 60 days
 years, months or days)

3. (a) PRINT FULL NAME

JAMES MCGOLDEN JONES

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

4. Sex m 5. Color or race negr 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased may 28 1899
 (Month) (Day) (Year)

8. AGE: Years 40 Months 9 Days 4 If less than one day hr. _____ min. _____

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

10. Usual occupation Delivery Boy for Feed Store

11. Industry or business

12. Name James Jones

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

14. Maiden name Carrie Patton

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

16. (a) Informant's own signature Mrs Martha Dean

(b) Address Huntersville Mo

17. (a) Removed (b) Date thereof May 5, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director Tom B Patton

(b) Address Huntersville Mo

19. (a) Mo (b) W. J. G. G. G.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
 (c) City or town Rural Silvercreek
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 2
 year 1940 hour 10:30 minutes pm

21. I hereby certify that I attended the deceased from 12/26, 1939, to Mar 2, 1940

that I last saw him alive on Mar 2, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Influenza Pneumonia (acute) Bright Disease D.K.
 Duration 6 days

Due to Blood Syphilis D.K.

Due to _____

Other conditions 34
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy none

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 P. V. Drayer M.D. (M. D. or other) 1

Address Huntersville Mo Date signed 3/4/40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MOTHER FATHER

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 *Tom B. [Signature]*

Licensed Embalmer No. *3914*

P. O. Address *Huntsville, Ala.*

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. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County _____
 (b) City or town _____
 (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)

3. (a) PRINT FULL NAME _____

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

- MOTHER FATHER { 12. Name _____
 18. 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's own signature _____
 (b) Address _____

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (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 Missouri (b) County Randolph
 (c) City or town Rural - Silvercreek
 (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 2
 year 1940 hour 10 30 minute P. M.

21. I hereby certify that I attended the deceased from 12/26/39
 _____, 19____, to Mar 2, 1940;
 that I last saw him alive on Mar 2, 1940
 and that death occurred on the date and hour stated above.

- Immediate cause of death Influenza Pneumonia Duration 6 days
(Bronchial)

- Due to Bright's Disease D.K.
Blood Syphilis D.K.
 Due to _____

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

- Major findings:
 Of operations _____
 Of autopsy none
 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)
 (e) Means of injury _____
 23. Signature Philip Dreyer M.D. (M. D. or other)
 Address Huntsville Mo. Date signed 3/4/40

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.

not to be used I X 1931

5-7894

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.....

Licensed Embalmer No.....

P. O. Address.....

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. 7894
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 737

Primary Registration District No. 5973

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

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Silver Creek, Mo.
(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

3. (a) PRINT FULL NAME James M. Galden Jones
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W
6. (b) Name of husband or wife Edua 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 40 Months 9 Days 4 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) June 20 - 1940 (b) A. J. Bradeher
(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.

20. DATE OF DEATH: Month May day 2
year 1940 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 _____
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 P. V. Brewer (M. D. or other) _____
Address Monticello, Mo. Date signed _____

SUPPLEMENTARY

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