

FILED APR 8 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH10170  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Boone Registration District No. 94  
 (b) Township Rockyfork Primary Registration District No. 4042  
 or  
 (c) City Hallsville (d) Street No. 25 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. 2 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Mrs. Emma J. Jones  
 (a) Residence, No. Hallsville, Mo. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Jones  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 9 - 1861  
 7. AGE YEARS 78 MONTHS 4 DAYS 13 If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co. Mo.

FATHER  
 13. NAME Thomas J. Barnes

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER  
 15. MAIDEN NAME Mary Bratton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co. Mo.

17. INFORMANT Fred Jones  
(ADDRESS) Hallsville Mo.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Red Top cemetery DATE May 24 1940

19. FUNERAL DIRECTOR (NAME) H. L. Shook  
(ADDRESS) Hallsville, Mo.

20. FILED 3-24-1940 Mrs. F. L. Lucett  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 22 1940

22. I HEREBY CERTIFY, That I attended deceased from Dec 1939 to Mar. 22, 1940

I last saw h. at alive on Mar. 23, 1940 Death is said to have occurred on the date stated above, at 5:30 p.m.

The principal cause of death and related causes of importance were as follows:

Coronary thrombosis of aorta & lungs

Date of onset

Other contributory causes of importance:

Name of operation none Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) M. J. Lucett M. D.

(Address) Centralia Mo.

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**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 *Charles Loring*  
Licensed Embalmer No. *41321*  
P. O. Address *Columbia, 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. 10170 <sup>7</sup>

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 74

Primary Registration District No. 4042

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

1. PLACE OF DEATH:

(a) County B Boone  
(b) City or town Hallsville  
(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 Mrs Emma Jones

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

4. Sex 7 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 78 Months 4 Days 13 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)

(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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH. Month mar day 22 year 1990 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 Carcinoma of pancreas and liver

Due to Primary not known

Other conditions (Include pregnancy within 3 months of death) 46

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 T. M. Turner (M. D. or other) \_\_\_\_\_

Address Celantalia, Mo signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

S-10170 1940