

No. 2  
11-10-39  
-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14957

MAY 15 1940 944  
Registration District No. 944

Primary Registration District No. 5438

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

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Rural Taylor  
(c) Name of hospital or institution: Strafford Route # 1  
(d) Length of stay: In hospital or institution 16 years  
In this community 16 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Rural  
(d) Street No. Strafford Route # 1  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME CLARENCE WESLEY JONES

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 Married

6. (b) Name of husband or wife Anna E. Jones 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased 60 October 8, 1879  
(Month) (Day) (Year)

8. AGE: Years 60 Months 5 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Johnson Co. Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

12. Name Kennard S. Jones

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

14. Maiden name Margaret Robinson

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

16. (a) Informant Anna E. Jones  
(b) Address Strafford Rt # 1

17. (a) Burial (b) Date thereof Mar. 20, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rollman Prairie

18. (a) Signature of funeral director G. C. Aramo  
(b) Address Springfield, Mo

19. (a) May-9-1940 (b) Harry Grier  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19  
year 1940 hour 12 minute 25 A.M.

21. I hereby certify that I attended the deceased from 3-16-40, 19\_\_\_\_, to 3-18-40, 19\_\_\_\_;  
that I last saw him alive on 3-18-40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Hypertensive Heart Disease

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? 930  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature C. Simpson M.D. (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo. Date signed 3-18-40

Duration 3 days  
? ?  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

**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 *R. H. Chene*

Licensed Embalmer No. 3681

P. O. Address Springfield, 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.**