

AY 15 1940

Registration District No. 284

Primary Registration District No. 5335

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howell
 (b) City or town RURAL Howell Twp.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
West Plains, Mo. Route 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution No
 (Specify whether
 In this community 66 years
 years, months or days)

8. (a) PRINT FULL NAME HARRY W. JONES 528

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Margaret Davidson 6. (c) Age of husband or wife if alive 74 years7. Birth date of deceased July 7, 1862
(Month) (Day) (Year)8. AGE: Years 77 Months 9 Days 11 If less than one day _____ hr. _____ min.9. Birthplace Fairfield Co., Pa.
(City, town, or county) (State or foreign country)10. Usual occupation Farmer11. Industry or business Own FarmMOTHER FATHER { 12. Name Wm. Z. Jones13. Birthplace Unknown Pa.
(City, town, or county) (State or foreign country)14. Maiden name Susan B. Caldwell15. Birthplace Unknown Pa.
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Earl Jones(b) Address West Plains, Mo.17. (a) Burial (b) Date thereof Apr. 21, '40
(Burial, cremation, or removal) Howell Valley Cem. (City or town) (County) (State) (Year)
Howell Twp.18. (a) Signature of funeral director Hal Thomburg(b) Address West Plains, Mo.19. (a) 4-20-40 (b) Vida W. Simons
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. West Plains, Mo. Route 1
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18
year 1940 hour 10 minute 30 P.M.21. I hereby certify that I attended the deceased from Apr - 18
18, 1940 to Apr - 18, 1940
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral thrombosis Duration _____Due to Arteriosclerosis

Due to _____

Other conditions g. p. n.
(Include pregnancy within 3 months of death)Major findings: None Of operations _____Of autopsy None22. 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 W. Stogome (M. D. or other) _____
Address West Plains, Mo. Date signed 3/20/40

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

WRITE LEGIBLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORDS
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.

I 19311

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 ~~XXX~~.....

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

RECEIVED

District Health Officer No. 5,

District File Number 570 543

Date Filed 5/10/40

Signed

Hal Thornburgh

Hal Thornburgh

Licensed Embalmer No. 3408

P. O. Address West Plains, 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.