

Registration District No. **318**

Primary Registration District No. **2001**

Registrar's No. **511**

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Springfield Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 weeks  
In this community 4 weeks (Specify whether years, months or days)

3. (a) PRINT FULL NAME Cooper Jones 520

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

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

6. (b) Name of husband or wife Lillie B. Rooney 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased January 11 - 1877  
(Month) (Day) (Year)

8. AGE: Years 1 63 Months 4 Days 28 If less than one day hr. min.

9. Birthplace Rock County, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Merchant

11. Industry or business

MOTHER FATHER { 12. Name John M. Jones  
13. Birthplace Rock County, Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name May J. Shea  
15. Birthplace Ky  
(City, town, or county) (State or foreign country)

16. (a) Informant Lillie B. Jones

(b) Address Walnut Grove, Mo

17. (a) Jan - 11 - 1940 (b) Date thereof June 11 - 1940  
(Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Missouri

18. (a) Signature of funeral director Walter Brown

(b) Address Walnut Grove, Mo

19. (a) June 11, 1940 (b) W. E. Naudley, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Walnut Grove, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9<sup>th</sup>  
year 1940 hour 7 minute 35 P. M.

21. I hereby certify that I attended the deceased from May 2, 1940, to June 9, 1940  
that I last saw him alive on June 9, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis chronic Duration 10 yrs

Due to Hypostatic Bronchopneumonia 5 dx

Other conditions (Include pregnancy within 3 months of death) 31

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_  
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? 984  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Robert Glynn (M. D. or other) MD  
Address Springfield, Mo Date signed 6/10/40

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

*Genea Burr*

Licensed Embalmer No. *7064*

P. O. Address *Walnut Grove, Wis.*

**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.**

X