

Registration District No. 213 Primary Registration District No. 3A14 State File No. _____ Registrar's No. _____

1. PLACE OF DEATH: Cole
(a) County Jefferson City, MO
(b) City or town Jefferson City, MO
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 hrs.
(Specify whether _____)
In this community _____
years, months or days 7 213

3. (a) PRINT FULL NAME JOE THOMAS JONES
3. (b) If veteran, name war no
3. (c) Social Security No. unknown

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Nellie Lang
6. (c) Age of husband or wife if alive 28 years
7. Birth date of deceased Feb. 22 - 1909
(Month) (Day) (Year)

8. AGE: Years 31 Months 6 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Cauden Co., MO (City, town, or county) (State or foreign country)

10. Usual occupation Wpa. Laborer Farmer

11. Industry or business _____

12. Name John Jones

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

14. Maiden name Estel Reinwater

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

16. (a) Informant Nellis Lang
(b) Address Rolland, MO

17. (a) Burial (b) Date thereof Aug 28 - 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cauden Co., MO

18. (a) Signature of funeral director G. Casey
(b) Address Irma, MO

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Miller
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Wman, MO
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26
year 1940 hour 4 minute 15 P. M.

21. I hereby certify that I attended the deceased from Aug 25, 1940
_____, 19____, to Aug 28, 19____,
that I last saw him alive on Aug 25, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Burns

Due to Kerosene Explosion

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) accident

(b) Date of occurrence Aug 25, 1940

(c) Where did injury occur? Rural, Miller, MO
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
in home

While at work? No (Specify type of place) (e) Means of injury Explosion

23. Signature Myron Jones (M. D. or other) _____
Address Brunley Date signed 8-28-40

Duration
8-25-40
8-25-40

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

Laura Adams

Registered Apprentice No. *211*

working under my personal supervision.

Signed

C. B. Bacey

Licensed Embalmer No. *2694*

P. O. Address *Boonville, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28306

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. 265

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town St Marys Hospital
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St Marys Hospital
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 90 hrs
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Joe Thomas Jones

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Nellie Lang 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 min.
31 6 4

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

10. Usual occupation W.P.A. Laborer

11. Industry or business Farmer

12. Name John Jones

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

14. Maiden name Ester Ramwater

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

16. (a) Informant Willie Lang

(b) Address Richland, Mo

17. (a) Burial (b) Date thereof Aug-28-1949
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Camden, Mo

18. (a) Signature of funeral director L. Casey

(b) Address Shrew, Mo

19. (a) 10-18-45 (b) D. B. Grooms
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26 year 1949 hour 49 minute 13 - A.M.

21. I hereby certify that I attended the deceased from Aug 25 1949 to Aug 25 1949 that I last saw him alive on Aug 25 and that death occurred on the date and hour stated above.

Immediate cause of death Burns
Kerosene Explosion

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..... (M. D. or other).....
Address..... Date signed.....

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

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

TEMPLE

