

FILED SEP 25 1940

State File No.

Registration District No. 5

Primary Registration District No. 3031

Registrar's No. 116

1. PLACE OF DEATH:

(a) County Nodaway
(b) City or town Maryville
(c) Name of hospital or institution: 1321 E 2nd St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 yrs.
In this community 22 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Nodaway
(c) City or town Maryville
(If outside city or town limits, write "RURAL")
(d) Street No. 1321 E 2nd St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME BENJAMIN FRANKLIN JONES

3. (b) If veteran, name war _____ 3. (c) Social Security No. 487-14-9428

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

6. (b) Name of husband or wife Mattie Delina Jones 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 13, 1873
(Month) (Day) (Year)

8. AGE: Years 67 Months 6 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name James Irvin Jones

13. Birthplace Randolph Co. Ind.
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Placock

15. Birthplace not known
(City, town, or county) (State or foreign country)

16. (a) Informant Chester Jones

(b) Address Maryville Mo Aug 29, 1940

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

(c) Place: burial or cremation Miriam Cemetery

18. (a) Signature of funeral director John W. Price

(b) Address Maryville Mo

19. (a) Aug 29, 40 (b) Manuel E. Clardy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 27
year 1940 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from Aug 23
1940 to Aug 27 1940
that I last saw him alive on Aug 25 1940
and that death occurred on the date and hour stated above.

Immediate cause of death stroke
with left side paralysis
Myocardial degeneration

Due to arterio-sclerosis

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? _____

5513 (Specify type of place) _____
While at work? (e) Means of injury _____

28. Signature H. M. Halli (M. D. or other) MO.

Address Maryville Mo Date signed 8-29-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

14
9
2

inc

132

RECEIVED

District Health Officer No. 11

District File Number 940-75880

Date Filed SEP 11 1948

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 John W. Price
Licensed Embalmer No. 3229

P. O. Address Maryville 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. **29236**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **620-**

Primary Registration District No. **3031**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County **Madison**
 (b) City or town **Marionville**
(If outside city or town limits write "RURAL" and name of township)
 (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 _____
years, months or days)

3. (a) PRINT FULL NAME **Benjamin J. Jones**
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **M**
 6. (b) Name of husband or wife _____
 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
67 6 14 hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER { 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 _____
(Burial, cremation, or removal) (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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **27**
 year _____ hour _____ minute _____ M.

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

Immediate cause of death: **Septicemia**
with left sided
paralysis
 Duration **sup cardiac degeneration**

Duration **Arteriosclerosis**
 Other conditions: **Central thrombosis**
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations: **JZC**
 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?

While at work? _____ (Specify type of place) _____
 (e) Means of injury _____

23. Signature **H. M. Hallis** (M. D. or other) **MD**
 Address **Marionville** Date signed **10-22-70**

SUPPLEMENTARY

