

No. 2
1-10-39
17-39
X21492

Registration District No. **391**

Primary Registration District No. **4230**

Registrar's No. **65**

1. PLACE OF DEATH:

(a) County IRON
(b) City or town IRONTON
(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) **2**

3. (a) PRINT FULL NAME RAYMOND JONES

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

4. Sex MALE 5. Color or race COLORED 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased AUGUST 29 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation PRE-SCHOOL **0**

11. Industry or business _____

MOTHER FATHER { 12. Name ELZA JONES **B**

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

14. Maiden name LUCY ANN GRAY **I**

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

16. (a) Informant MRS. FRANCES GRAY

(b) Address IRONTON, Mo.

17. (a) BURIAL (b) Date thereof 11-13-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation IRONTON COLORED CEMETERY

18. (a) Signature of funeral director Geo. P. ...

(b) Address Ironton, Mo.

19. (a) Dec - \$40 (b) Julius ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County IRON
(c) City or town IRONTON
(If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 13
year 40 hour 7:00 minute 21 A.M.

21. I hereby certify that I attended the deceased from 11/13, 1940, to 11/13, 1940
that I last saw him alive on 11/13, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death congenital heart failure
Due to congenital heart disease
Due to _____

Duration
11/13/40
8/29/40

Other conditions ONE OF TWINS
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____ **15!**
Of autopsy _____

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

23. Signature R. E. Harland M.D. (M. D. or other) **I**
Address Ironton, Mo. Date signed 11/15/40

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.....

Licensed Embalmer No.....

P. O. Address.....

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. 38848

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 391

Primary Registration District No. 4230

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Iron
(b) City or town Fronton
(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

Raymond Jones

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race col

6. (a) Single, widowed, married, divorced 8

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 min.
2 14 _____ min.

9. Birthplace _____

(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Dec 3-46

(Date received local registrar)

(b) Julia A. Guntor

(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 11 day 13
year 1946 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 _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

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? _____

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

23. Signature P. E. Harlan M. D. or other) _____

Address Fronton Mo Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

S-38848 1940.