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FILED JUL 15 1941

STANDARD CERTIFICATE OF DEATH

State File No.

Non District No.

1014 Primary Registration District No.

455

Registrar's No.

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Granby Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community all of life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton
(c) City or town Granby Mo.
(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.

3. (a) PRINT FULL NAME John William Jones

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 Martha Jones 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 1 22 hr. min.

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

10. Usual occupation farmer

11. Industry or business

12. Name Don't Know
13. Birthplace Don't Know
(City, town, or county) (State or foreign country)
14. Maiden name Don't Know
15. Birthplace Don't Know
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Judge

(b) Address Granby, Missouri

17. (a) Burial (b) Date thereof June 9 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maciboy

18. (a) Signature of funeral director James + Wheeler

(b) Address Cassville Mo.

19. (a) June 8 '41 (b) R. E. Rolens
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7
year 1941 hour 1:30 minute P. M.

21. I hereby certify that I attended the deceased from June 1 1941
June 7, 1941, to _____, 19____;
that I last saw him alive on June 6, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Paraplegia
Duration 6 mo

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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? _____

544 While at work? _____ (Specify type of place) _____ (e) Means of injury 0

23. Signature R. E. Rolens (M. D. or other) _____

Address Granby Mo Date signed 6-8-41

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

MOTHER FATHER

832

AUG 7 1941

25-4
SEBEX I

RECEIVED

District Health Officer No. 6;

District File Number 741-1213

Date Filed JUL 14 1941

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 Robert Bennett

Licensed Embalmer No. 4213

P. O. Address Asheville, Mass

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. 22293

Registration District No. 614

Primary Registration District No. 455

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Granby
(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 John W. 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 _____ year
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

(Data received local registrar)

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7
year 1941 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 _____
Paraplegia

Due to Spinal meningitis

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

Duration
6 mo

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

Granby, Mo

