

FILED JUL 17 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

22436
Do not use this space. R.

1. PLACE OF DEATH

(a) County PLATTE Registration District No. 648
(b) ~~Township~~ WESTON Primary Registration District No. 4420
(c) City WESTON or (d) Street No. 1
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME DORA GOOD PASTURE JONES

(a) Residence, No. _____ St. _____ (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ED JONES
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS 67 MONTHS 11 DAYS 19 If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWIFE
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) OWENSVILLE (STATE OR COUNTRY) KENTUCKY

13. NAME J. H. Goodpasture

14. BIRTHPLACE (CITY OR TOWN) Kentucky (STATE OR COUNTRY)

15. MAIDEN NAME Plyne Collins

16. BIRTHPLACE (CITY OR TOWN) Kentucky (STATE OR COUNTRY)

17. INFORMANT Ed Jones (ADDRESS) Weston, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Pleasant Ridge DATE June 7 1941

19. FUNERAL DIRECTOR (NAME) W. R. Vaughn (ADDRESS) Weston Mo.

20. FILED 6/7 1941 J. H. Brill Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June, 1941

22. I HEREBY CERTIFY That I attended deceased from May 20, 1941, to June 4, 1941. I last saw her alive on June 4, 1941. Death is said to have occurred on the date stated above, at 1:00 p.m.. The principal cause of death and related causes of importance were as follows:

Endocarditis Acute - Cerebral Hemorrhage - Nephritis Chronic
Date of onset 5/20/41

Other contributory causes of importance: Fracture of R. hip (femur) Arteriosclerosis
Date 5/29/41

Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? yes Date of injury 5/29, 1941. Where did injury occur? at home (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fall due to cerebral accident
Nature of injury fracture of hip

24. Was disease or injury in any way related to occupation of deceased? If so, specify _____ (Signed) J. H. Brill, M. D. (Address) Weston, Mo.

N. E.—every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 698

Primary Registration District No. 4920

Registrar's No. _____

1. PLACE OF DEATH: Platte

(a) County _____

(b) City or town _____
(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. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Platte

(c) City or town Wesley
(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 _____

3. (a) PRINT FULL NAME Lera Good Pasture Jones

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

20. DATE OF DEATH: Month June day 4
year 1944 hour _____ minute _____ M.

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife Ed Jones 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased June 15 191874
(Month) (Day) (Year)

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6/7/1944 (b) J. H. Baird
(Date received local registrar) (Registrar's signature)

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) _____

SUPPLEMENTARY

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

MOTHER FATHER

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

S-22436