

0. 2
4-41
17-39
X26390

FILED SEP 15 1941

State File No. _____

Registration District No. 318

Primary Registration District No. 5440

Registrar's No. 685

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
MEDICAL CENTER FOR FEDERAL PRISONERS
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Yr. 3 Mos. 27 Days
In this community 1 Year 8 Mos. & 17 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Territory: Alaska (b) County None
(a) ~~SITKA~~
(c) City or town Sitka
(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 D

039
0
e

3. (a) PRINT FULL NAME JONES, Alfred M.

3. (b) If veteran, name war None
3. (c) Social Security No. Unknown

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

6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased May 29, 1915
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
26 2 23 hr. min.

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

10. Usual occupation Fisherman

11. Industry or business _____

MOTHER FATHER { 12. Name Phillip C. Jones
13. Birthplace Sitka, Alaska
(City, town, or county) (State or foreign country)
14. Maiden name Annie Jones
15. Birthplace Unknown, Alaska
(City, town, or county) (State or foreign country)

16. (a) Informant Deceased

(b) Address _____

17. (a) Burial (b) Date thereof August 26, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn

18. (a) Signature of funeral director W. E. Handley

(b) Address Springfield, Mo.

19. (a) 8-26-41 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22
year 1941 hour 6 minute 23 A.M.

21. I hereby certify that I attended the deceased from December 5,
1939 to August 22, 1941
that I last saw him alive on August 22, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, Pulmonary, Chronic, far advanced bilateral.

Secondary Diag: Dislocation, congenital, hip joints, bilateral.
Due to _____

Other conditions (Include pregnancy within 5 months of death) _____

Major findings: Of operations Phrenic crush, right.

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 W. E. Handley (M. D. of _____)
Address Springfield, Missouri Date signed 8/25/41
Clinical Director

Duration of Admission to _____

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

R.H. [Signature]

Licensed Embalmer No. *3681*

P. O. Address *Springfield, 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.