

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28831

Registration District No. 639

Primary Registration District No. 4320

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Rural - Marquand Twp
(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 6 months years, months or days)

8. (a) PRINT FULL NAME Hazel Elaine Jones

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

6. (b) Name of husband or wife T. P. Jones (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Oct 10 1911
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>29</u>	<u>10</u>	<u>21</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Harry Clark

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

14. Maiden name Therese (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Thos. P. Jones

(b) Address Marquand, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-41 (Month) (Day) (Year)

(c) Place: burial or cremation Marquand Mo

18. (a) Signature of funeral director Amend

(b) Address Marquand, Mo.

19. (a) Sept 1 1941 (Date received local registrar) (b) B. C. Scaughley (If registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison

(c) City or town Rural Marquand (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. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 31 year 1941 hour 10 minute 40 A.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.

Immediate cause of death Gun shot wound
Chest tearing out heart

Due to _____

Due to _____

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

Major findings: 164C
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence Aug - 31 - 1941

(c) Where did injury occur? Rural Marquand - Madison - MO. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Home (Farm)

While at work? NO (Specify type of place) (e) Means of injury Shot gun wound

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

Address Amendertown Date signed 9/1/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

N. B.—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.

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.