DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 9 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32293

Registration District No. 668 — Primary Registration District No. 3032 — Registrar's No. 280

X26390

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

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia Co. Ins

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital # 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether

In this community 0 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis

(c) City or town Sedalia (If outside city or town limits, write "RURAL")

(d) Street No. Hospital no 2 (If rural, give location)

(e) Citizen of foreign country? ~~(Yes~~ or No)

If yes, name country 0

3. (a) PRINT FULL NAME WILLIAM M. JONES

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M. 2

5. Color or race Col

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

6. (b) Name of husband or wife Unknown

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

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

8. AGE: Years	Months	Days	If less than one day
about 65			hr. min.

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

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Elmer Washington

(b) Address 211 E Cooper St Sedalia Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-41 (Month) (Day) (Year)

(c) Place: burial or cremation Georgetown Mo

18. (a) Signature of funeral director F H Ferguson

(b) Address

19. (a) 9/13/41 (Date received local registrar) (b) Mrs. Harry Sneed (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month # day Sept 11 year 1941 hour 530 minute P M.

21. I hereby certify that I attended the deceased from Sept 3rd 1941, to Sept 11 1941 that I last saw him alive on Sept 11 1941 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Stroke of Paralysis	11 day
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature P H C Dunsey (M. D. or other) D

Address Sedalia Mo Date signed 9/13-41

90 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-7-41

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 F. D. Ferguson

Licensed Embalmer No. 21 [illegible]

P. O. Address Sedalia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—8-21-41
I X29288

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State File No. 32293

Registration District No. 668 Primary Registration District No. 3032 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia
(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 (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

3. (a) PRINT FULL NAME William Jones

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

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

6. (b) Name of husband or wife

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

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

8. AGE: Years about 65 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

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day
year 1941 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.

	Duration
Immediate cause of death	
Stroke of Paralysis	
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.

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(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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

Ascending Paralysis 82:1