

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

FILLED NOV 21 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35129**

Registration District No. **384**

Primary Registration District No. **4227**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Howell**
 (b) City or town **West Plains**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **West Plains Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 week**
 In this community **0** years, months or days (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Audrey Mae Jones**

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

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

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

7. Birth date of deceased **Dec. 20 1925**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	15	8	8	hr. _____ min.

9. Birthplace **Rover Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Student**

11. Industry or business _____

12. Name **Henderson Jones**

13. Birthplace **Oregon County Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Mimmie Perkins**

15. Birthplace **Oregon County Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Henderson Jones**

(b) Address **Thayer, Mo. Route 1**

17. (a) **Burial** (b) Date thereof **9-10-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Howell Cem.**

18. (a) Signature of funeral director **Leo Carr**

(b) Address **Thayer, Mo.**

19. (a) **9-21-41** (b) **Vida W. SIMONS**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Oregon**
 (c) City or town **Thayer Route 1**
 (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 **Sept.** day **8**
 year **1941** hour **1:00** minute **A.** M.

21. I hereby certify that I attended the deceased from **7/5**, 19**41**, to **9/8**, 19**41**.
 that I last saw her alive on **9/8**, 19**41**,
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Acute Nephritis Duration **18 days**

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? _____

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

23. Signature **Minnie Stauber** (M. D. or other) **MD**
 Address **West Plains Mo** Date signed **9/24/41**

RECEIVED

District Health Officer No. 5,

District File Number. 11412052

Date filed _____

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. 281-2

P. O. Address _____

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

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

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STANDARD CERTIFICATE OF DEATH

Registration District No. 384

Primary Registration District No. 4227

Registrar's No.

1. PLACE OF DEATH:

(a) County Howell
(b) City or town West Plains
(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 Rudrey M. 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 S

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

7. Birth date of deceased Dec 20 1922
(Month) (Day) (Year)

8. AGE: Years 15 Months 8 Days no.
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)..... (b).....
(Date received local registrar) (Registrar's signature)

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..... day.....
year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....
that I last saw him/her alive on....., 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Acute Nephritis
Chr Interstitial Nephritis
Due to.....
Due to.....

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

Major findings:
Of operations.....

Of autopsy..... 1310

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

