

DEC 10 1941

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

39155
Do not use this space.

1. PLACE OF DEATH

(a) County Polk Registration District No. 703
(b) Township Jackson Primary Registration District No. 4424 Registered No. 2000
(c) City Humansville (d) Street No. Sub. Dr. Emmitt Memorial Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME X

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

Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED + 0

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11/24/41

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 12 hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. X
9. Industry or business in which work was done, as saw mill, bank, etc. X
10. Date deceased last worked at this occupation (month and year) X
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Humansville (STATE OR COUNTRY) Missouri

13. NAME Oren Lingle Jones
14. BIRTHPLACE (CITY OR TOWN) Stockton (STATE OR COUNTRY) Missouri

15. MAIDEN NAME Jane Estella Brandon
16. BIRTHPLACE (CITY OR TOWN) Stockton (STATE OR COUNTRY) Mo

17. INFORMANT Oren Lingle Jones (ADDRESS) Stockton Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Stockton DATE 11-26 1941

19. FUNERAL DIRECTOR (NAME) Chas. Neal (ADDRESS) Stockton Missouri

20. FILED Nov. 27, 1941 Ora M. Rush Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/25 1941

22. I HEREBY CERTIFY, That I attended deceased from 1-24 1941 to 11-25 1941

I last saw him alive on 11/25 1941. Death is said to have occurred on the date stated above, at 8:00 P. m.

The principal cause of death and related causes of importance were as follows:

Intracranial Hemorrhage due to blunt injuries.

Date of onset

Other contributory causes of importance:

1600c

Name of operation 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? Date of injury , 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify G. Y. Robinson M. D. (Address) Humansville, Mo.

Statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 7;

District File Number 12-41-2012

Date Filed 12-9-41

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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.

ЗАПИСЬ ВЪВЕДЕНА В ОФИЦИАЛЬНУЮ ЗАПИСЬ ЗАРЕГИСТРИРОВАННЫХ ЭМБАЛИРОВЩИКОВ

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39155

Registration District No. 703

Primary Registration District No. 4424

Registrar's No.

1. PLACE OF DEATH:

(a) County Polk
(b) City or town Johnson
(c) Name of hospital or institution:
(If outside of town limits, write "RURAL" and name of township)
(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 Cedar
(c) City or town Stockton
(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 Infant 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.....
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Mar. 29 1945
(Month) (Day) (Year)

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.....

MOTHER FATHER { 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..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....
19. (a) Nov. 27-41 (b) Ora M. Rich
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 25 year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
(Immediate cause of death.....)

Duration

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..... (M. D. or other)
Address..... Date signed.....

WRITE IN BLACK INK—MAKE A PERMANENT RECORD

WRITE IN INK

SUPPLEMENTARY

S-39155