

JAN 13 1942

Registration District No. 309

Primary Registration District No. 5427

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Gentry  
(b) City or town Albany Rural Athens 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. 40 years (Specify whether  
In this community. 40 years  
years, months or days)

3. (a) PRINT FULL NAME Carl C. Jonagan

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife. Bernice Rice 6. (c) Age of husband or wife if alive 58 years  
7. Birth date of deceased December 14 1871  
(Month) (Day) (Year)

8. AGE: Years 69 Months 11 Days 18 If less than one day  
..... hr. .... min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name Alfred Jonagan  
13. Birthplace Canton, Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Frances Endolph  
15. Birthplace Canton Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Carl Jonagan  
(b) Address Albany, Mo. R.F.D.

17. (a) Burial (b) Date thereof 12-4-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation. Grandview Cemetery

18. (a) Signature of funeral director [Signature]  
(b) Address Albany, Missouri

19. (a) Dec. 5, 41 (b) W. Martin  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gentry 38  
(c) City or town Albany, Rural Athens Twshp 9  
(If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country .....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 2  
year 1941 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from Oct 11 1941, to Nov 2 1941.  
that I last saw h. 1 m alive on ..... 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death ursemie ✓ Duration  
Due to Passurey 20  
Due to Following auto day  
operation  
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 J. N. Barger (M. D. or other) 0  
Address Albany Mo Date signed

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 me

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

Signed *Clifford B. Bush*

Licensed Embalmer No. 3329

P. O. Address Albany, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41829

Registration District No. 309

Primary Registration District No. 5427

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County Sentry  
 (b) City or town Albany  
(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** Carl C. Jonagan  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color 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 Dec 14 1871  
(Month) (Day) (Year)

**8. AGE:** Years 69 Months 11 Days 18  
If less than one day \_\_\_\_\_ 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 \_\_\_\_\_  
(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 Dec 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 Uremia  
operating

Due to Bronch  
Nephritis  
 Due to was operated on Oct  
1941 On state city  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**PHYSICIAN**  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 1376

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 PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

STATE OF NEW YORK

IN SENATE  
January 10, 1911.

REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 11, 1909.

ALBANY:  
J. B. LIPPINCOTT COMPANY,  
PRINTERS,  
1911.

THE STATE OF NEW YORK: DEPARTMENT OF THE COMMISSIONERS OF THE LAND OFFICE, ALBANY, 1911.