

No. 2  
-1-4-41  
5-17-39  
I X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

42313

State File No. \_\_\_\_\_

JAN 10 10 10 277

Registrar's No. 10

Registration District No. \_\_\_\_\_

Primary Registration District No. 5-6/11

3000  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH**

(a) County Laclede

(b) City or town Smith township Rural  
(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 40 years  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County Laclede

(c) City or town Smith township Rural  
(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 \_\_\_\_\_

**3. (a) PRINT FULL NAME** Luther Marion Jones

3. (b) If veteran, \_\_\_\_\_ name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 10 day 17  
year 1941 hour 11 minute 15 a M.

21. I hereby certify that I attended the deceased from Jan 20  
1941 to Oct 17 1941;  
that I last saw him alive on Oct 17 1941  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 1

7. Birth date of deceased 4 1871  
(Month) (Day) (Year)

8. AGE: 70 Years Months 6 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Chronic Valvular Heart disease Duration 10 yrs

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

10. Usual occupation Retired farmer

Due to \_\_\_\_\_

Due to 93d

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

11. Industry or business guard

**MOTHER FATHER**

12. Name Savil James

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

14. Maiden name Lynchburg Va

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

Major findings: Of operations ✓

Of autopsy \_\_\_\_\_

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

16. (a) Informant Charles Montgomery

(b) Address Richland Mo

17. (a) Smulson Cem (b) Date thereof 10-18-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation burial in Smulson Cem

18. (a) Signature of funeral director Vergil M. Gussner

(b) Address Stoutland Mo

19. (a) 10-18-41 (b) C.E. Coster  
(Date received local registrar) (Registrar's signature)

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 C.E. Coster (M. D. or other) U

Address Stoutland Mo Date signed 10-17-41

RECEIVED

District Health Officer No. ....  
District File Number 1-42-33  
Date Filed Jan 8 1942

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, fact should be so stated above.