N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 10 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11170

Registration District No. 469 (47)

Primary Registration District No. 5639

Registrar's No. 47

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mt Vernon R H 1 Tr.
(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 0 (Specify whether
In this community —
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dade 029 0

(c) City or town Everton Mo 0
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME J. Mitt Jones

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 Ada

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Jan (Month) 19 (Day) 1872 (Year)

8. AGE:

Years	Months	Days	If less than one day
70	3	11	hr. min.

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

10. Usual occupation R.R. Section

11. Industry or business —

FATHER
12. Name Jimmie Jones
13. Birthplace Dade Co Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Not known
15. Birthplace — (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Geo Morris

(b) Address Mt Vernon Mo. Rt #1

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

(c) Place: burial or cremation Lorend Cemetery

18. (a) Signature of funeral director J. W. Ward

(b) Address Greenfield Mo

19. (a) Mar 32-42 (Date received local registrar) (b) Dodgah L. Morris (Registrar's signature) Dep.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31 year 1942 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb-20, 1942, to 3-31, 1942 that I last saw h — alive on 3-31, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Ch myocarditis	
Due to Infect. of hand	5 wks
Due to	
Other conditions (Include pregnancy within 3 months of death) Colles Fracture	
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 R. S. Cowan (M. D. or other)

Address Aurora, Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 442-468
Date Filed APR 9 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 J. W. Ward

Licensed Embalmer No. 2832

P. O. Address Greenfield Mo

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

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

No. 2B
8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11170

Registration District No. 476 Primary Registration District No. 5633 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town 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 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 J Mitt 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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 19 (Day) 1872 (Year)

8. AGE: Years 70 Months 3 Days 1 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 day
year 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.

Immediate cause of death ~~Collis Tractene~~

Due to

Due to 93d

Other conditions Collis Tractene (Comp)
(Include pregnancy within 3 months of death)
5 wks before death was

Major findings:
Of operations probably a contributory factor
Of autopsy but death was due to Ch. Myocarditis

Duration

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) no

(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 R Lowan (M. D. or other) MD

Address Aurora, Mo Date signed

S-11170 1942