No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 25 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21353

Registration District No. 384 Primary Registration District No. 55 36 Registrar's No.

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

6 0 0

1. PLACE OF DEATH:
(a) County: HOWELL
(b) City or town: RURAL HOWELL TWP.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: WEST PLAINS, MO. / R.R. #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: No. (Specify whether
In this community: 31 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: HOWELL 46
(c) City or town: RURAL 6
(If outside city or town limits, write "RURAL")
(d) Street No.: WEST PLAINS, MO. R.R. 1 0
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: SARAH EVA 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: MARRIED
6. (b) Name of husband or wife: GEO. HENRY JONES
6. (c) Age of husband or wife if alive: 82 years
7. Birth date of deceased: NOV. (Month) 28 (Day) 1861 (Year)

8. AGE: Years	Months	Days	If less than one day
80	0	0	hr. min.

9. Birthplace: GOSPORT, (City, town, or county) INDIANA / (State or foreign country)
10. Usual occupation: HOUSEWIFE
11. Industry or business:
MOTHER FATHER
12. Name: STEPHEN HICKMAN DRAKE
13. Birthplace: (City, town, or county) KY. / (State or foreign country)
14. Maiden name: REBECCA EMMALINE BROWN
15. Birthplace: (City, town, or county) UNKNOWN 4 (State or foreign country)
16. (a) Informant: GEO. H. JONES
(b) Address: WEST PLAINS, MO. R.R. 1
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: DEC. 1, 1941 (Day) (Year)
HOWELL VALLEY (Cemetery)
(c) Place: burial or cremation: HOWELL CO., MO.
18. (a) Signature of funeral director: Hal Thornburgh
(b) Address: WEST PLAINS, MO.
19. (a) 12-1-41 (Date received local registrar) (b) Vida W. Simons (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 28
year 1941 hour 7: minute A. M.
21. I hereby certify that I attended the deceased from Oct. 3, 1941, to Nov. 28, 1941; that I last saw her alive on Nov. 18, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Nephritis, chronic — several yrs.
Liver and
Due to: 131 f
Due to:
Other conditions (Include pregnancy within 3 months of death): Liver & Gall bladder infection, chronic

Duration

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): not.
(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: A. H. Thornburgh, M. D. (M.D. or other) M.D.
Address: West Plains, Mo. Date signed 12/1/41

1125 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 44239
Date Filed 7-20-72

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 Hal Thornburgh

Licensed Embalmer No. 3408

P. O. Address West Plains, M

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.