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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 13 1942

Registration District No. 878

Primary Registration District No. 6157

Registrar's No. 24

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

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural Montevallo town
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Montevallo, RR #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 4 days
years, months or days

2. USUAL RESIDENCE OF DECEASED: 108

(a) State MO (b) County Vernon

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Montevallo mo R. #1
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME NATHAN-DANIAL-JONES

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15
year 1942 hour 11 minute 25 P.M.

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

21. I hereby certify that I attended the deceased from June 12, 1942 to June 15, 1942
that I last saw him alive on June 12, 1942
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Jennie Jones 6. (c) Age of husband or wife if alive 10 years

7. Birth date of deceased sept 10 1863
(Month) (Day) (Year)

Immediate cause of death Uremia

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>9</u>	<u>5</u>	hr. _____ min. _____

Due to Uremia and Hypertrophied prostate

Due to _____

9. Birthplace unknown Tenn
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation Farming

11. Industry or business _____

PHYSICIAN _____

Major findings: _____
Of operations _____
Of autopsy _____

Underline the cause to which death should be charged statistically.

12. Name Daniel Jones

13. Birthplace unknown Tenn
(City, town, or county) (State or foreign country)

14. Maiden name unknown

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

16. (a) Informant Robert Jones

(b) Address Montevallo mo

17. (a) Burial (b) Date thereof June 18 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheldon Cemetery

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? _____

18. (a) Signature of funeral director Sheldon Jones
Sheldon Jones

(b) Address _____

While at work? _____ (Specify type of place) (c) Means of injury _____

19. (a) June 18, 1942 (b) Glesener Ludwig
(Date received local registrar) (Registrar's signature)

23. Signature C. E. Dierckx (M. D. or other) MD

Address Panna mo Date signed 6/16/42

RECEIVED

District Health Officer No. 7,

District File Number 7-42-750

Date Filed 7-10-42,

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 Carroll T. Beery

Licensed Embalmer No. 2385

P. O. Address Sheldon 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22493

Registration District No. 878

Primary Registration District No. 6157

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Vermon
(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 4 days years, months or days

3. (a) PRINT FULL NAME Nathan Daniel 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 W

6. (b) Name of husband or wife Jennie 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 10 1943 (Month) (Day) (Year)

8. AGE: Years 78 Months 9 Days 13 (If less than one day) min.

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

10. Usual occupation _____

11. Industry of business _____

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 Jan 1942 year 1942 hour 5:00 minute 50 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 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 Duration _____

Due to Chronic nephritis

Due to Cystitis from acute prostatitis

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 1316

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 C. E. Duckett (M. D. or other) MD
Address Lamar, Mo Date signed 8-18-42

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

SUPPLEMENTARY

MOTHER FATHER

S-22493