

FILED NOV 18 1942

State File No.

Registration District No.

Primary Registration District No. 3002

Registrar's No. 150

1. PLACE OF DEATH:
 (a) County Audrain Co.
 (b) City or town Mexico, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution General Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution about 18 hrs.
 (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Audrain
 (c) City or town Mexico
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1115 W. Ratney
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Infant son of Mrs. Clyde Jones
 3. (b) If veteran, name war _____
 3. (c) Social Security No. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 16
 year 1942 hour 3:55 P.M. minute _____ M. _____
 21. I hereby certify that I attended the deceased from Oct 16 1942 to Oct 17 1942
 that I last saw him alive on Oct 17 - 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 single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death premature birth
7 1/2 mo.
 Due to second of birth of twins
 Due to _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)
 8. AGE: Years _____ Months _____ Days _____ If less than one day 1 1/2 hr. min. _____

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.

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

10. Usual occupation none
 11. Industry or business _____
 12. Name Clyde F. Jones
 13. Birthplace Montgomery Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Eug. Krause
 15. Birthplace Callaway Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Clyde F. Jones
 (b) Address 1115 W. Ratney St. Mexico
 17. (a) Burial (b) Date thereof 11-18-1942
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mexico Mo.
 18. (a) Signature of funeral director M. J. Phipps
 (b) Address Mexico Mo.
 19. (a) 10-17-1942 (b) Margaret Macho
 (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?
 While at work _____ (Specify type of place) _____
 (e) Means of injury _____
 23. Signature R. Van Hagen
 (M. D. or other) _____
 Address Mexico, Mo. Date signed 10/17/42

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

41
39
29484

100

id. in case of ...
to ... of ...
at ...

RECEIVED

District Health Officer No. 10

District File Number 11-42-30209-393

Date Filed NOV 17 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 Roy A. McPherson

Licensed Embalmer No. 1133

P. O. Address Meyers, Pa.

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.

2B
J-21-41
X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 365-59

Registration District No. 10

Primary Registration District No. 3002

Registrar's No. 100

1. PLACE OF DEATH:

(a) County Anderson

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

(c) Name of hospital or institution: General Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 hrs.
(Specify whether years, months or days)

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 Infant son - Jane

3. (b) If veteran, name war

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16
year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 19 ;
that I have a day on 19 ;
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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct - 16 - 1942
(Month) (Day) (Year)

Immediate cause of death

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

8. AGE:

Years	Months	Days	If less than one day
<u> </u>	<u> </u>	<u> </u>	<u> </u> min.

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

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)

Major findings:

Of operations

Of autopsy

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 6

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-36559 1942

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