

MAR 19 1943  
Registration District No. 270

Primary Registration District No. 3033

1. PLACE OF DEATH:  
(a) County Laclede  
(b) City or town Lebanon  
(c) Name of hospital or institution: Wallace Hospital  
(d) Length of stay: In hospital or institution 2 Days  
In this community 18 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Laclede  
(c) City or town Rural  
(d) Street No. Drummond Missouri  
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME JOHN CALVIN JONES  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month February day 19  
year 1943 hour 9.2 minute 30 AM.  
21. I hereby certify that I attended the deceased from 2/17 1943 to 2/19 1943  
that I last saw him alive on 2/19 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 Married  
6. (b) Name of husband or wife Nora Fleming 6. (c) Age of husband or wife if alive 42 years  
7. Birth date of deceased December 5 1897

Immediate cause of death: gastric hemorrhage esophageal varices  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

8. AGE: Years 55 Months 2 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Wright CO MO  
10. Usual occupation Highway MAINTAINER  
11. Industry or business \_\_\_\_\_  
12. Name Lebanon Jones  
13. Birthplace TENN  
14. Maiden name Mattie Bell Wilson  
15. Birthplace PROVE SPRINGS MO

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

16. (a) Informant Martin Jones  
(b) Address Lebanon Mo  
17. (a) Burial (b) Date thereof 2-21-43  
(c) Place: burial or cremation Morgan  
18. (a) Signature of funeral director Palmer's  
(b) Address Lebanon Mo  
19. (a) 2-20-43 (b) Grace Roper

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(c) Means of injury \_\_\_\_\_  
23. Signature James L. Hope (M. D. or other) \_\_\_\_\_  
Address Lebanon, Mo Date signed 2/19/43

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

MOTHER FATHER

Duration 2 days  
Underline the cause to which death should be charged statistically.

# RECEIVED

District Health Officer No. *Lakeview County Health Unit*  
District File Number *2-43-27*  
Date Filed *3-16-43*

MAR 24 1943

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## 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 *Alvin Dechenage*  
Licensed Embalmer No. *4333*  
P. O. Address *Suburban 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10669

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Laclede

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

(c) Name of hospital or institution: Wallace Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether 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 John Calvin Jones

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

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

4. Sex m Color or race w

6. (a) Single, widowed, married, divorced n

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Dec 5 1888  
(Month) (Day) (Year)

8. AGE: Years 55 Months 2 Days 0  
If less than one day 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 \_\_\_\_\_

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 6 Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I saw him \_\_\_\_\_ live on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death gastric hemorrhage

Due to esophageal varices and

Due to ulcerative condition

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

Major findings: Of operations \_\_\_\_\_

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

Duration 2 days

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

5-10669