FILED APR 7 1943

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

11169
Do not use this space.

1. PLACE OF DEATH
(a) County Pulaski — Registration District No. 290
(b) Township Cullen — Primary Registration District No. 4427 — Registered No. 46
(c) City ..... (d) Street No. 1 ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME SHIRLEY MAY JONES
(a) Residence, No. ..... St. ☐ ..... (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: — Jan. 17, 1943
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE: YEARS — MONTHS 1 — DAYS 18 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. —
9. Industry or business in which work was done, as saw mill, bank, etc. —
10. Date deceased last worked at this occupation (month and year) —
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lebanon, Mo.

FATHER
13. NAME Fred E. Jones
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sparta, Mo.

MOTHER
15. MAIDEN NAME Anna Marie Wiseman
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Richland, Mo.

17. INFORMANT (ADDRESS) Fred E. Jones, Waynesville, Mo.
18. BURIAL, CREMATION, OR REMOVAL Mo. Lodide, Co.
PLACE ..... DATE 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) [illegible]
20. FILED 3-15- 1943 Chas. McCodd
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 7, 1943

22. I HEREBY CERTIFY, That I attended deceased from ——, 19..., to ——, 19...
I last saw h— alive on ——, 19... Death is said to have occurred on the date stated above, at 6:30 A m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pneumonia, bronchial	2-9-43

Other contributory causes of importance:

Name of operation —— Date of .....
What test confirmed diagnosis? no Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? —— Date of injury ——, 19...
Where did injury occur? ——
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury ——
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) C. Mallette, Coroner, M.D.
(Address) Crocker, Mo.

Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING [illegible] THIS IS A PERMANENT RE[illegible]
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.
I X14028

RECEIVED
Pulaski County Health Officer
File Number 4-43-45
Filed 4-5-43

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

. S. No. 2B
M—8-21-41
I 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. 11164

Registration District No. 290 Primary Registration District No. 4427 Registrar's No. 46

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Pulaski

(b) City or town
(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 Shirley May Jones

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 Jan (Month) 17 (Day) 1843 (Year)

8. AGE: Years | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (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 March Day 7
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw him alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia bronchial

Due to No complications

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 107

Of autopsy

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)

(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 C. Mallette Coroner (M.D. or other)

Address Crocker, Mo. Date signed 5-1-43

S-11169