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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14955

FILED APR 1 1940

Registration District No. 240

Primary Registration District No. 4358

Registrar's No. 62

72
2
0

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

1. PLACE OF DEATH:

(a) County New Madrid

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

(c) Name of hospital or institution: 1
(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: 72

(a) State Mo (b) County New Madrid

(c) City or town Lilbourn 2 0
(If outside city or town limits, write "RURAL")

(d) Street No. ____
(If rural, give location)

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

3. (a) PRINT FULL NAME: HENERY JONES.

3. (b) If veteran, name war —

3. (c) Social Security No. 498-12-9015

4. Sex Male

5. Color or race Col.

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Lillie B Jones.

6. (c) Age of husband or wife if alive 19 years

7. Birth date of deceased — (Month) — (Day) 1906 (Year)

8. AGE: Years 37 Months — Days — If less than one day ____ hr. ____ min.

9. Birthplace Ark. (City, town, or county) 1 (State or foreign country)

10. Usual occupation Farming

11. Industry or business —

FATHER
12. Name Unk
13. Birthplace Ark (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Anne Gray
15. Birthplace Ark. (City, town, or county) 1 (State or foreign country)

16. (a) Informant Lillie B Jones
(b) Address Lilbourn Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 — 9 43 (Month) (Day) (Year)
(c) Place: burial or cremation Catron Mo

18. (a) Signature of funeral director County Jol.
(b) Address N. M.

19. (a) 4-1-1943 (Date received local registrar) (b) Mrs. I. L. Parrett (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 4 year 43 hour 10 minute P M.

21. I hereby certify that I attended the deceased from Feb 5, 1943 to 6, 1943 that I last saw him alive on Feb 6, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Syphilis

Due to ____

Due to ____

Other conditions 309
(Include pregnancy within 3 months of death)

Major findings:
Of operations ____

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 0

23. Signature G. N. Wilson (M. D. or other)

Address Lilbourn Date signed 3-9-43

1216

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 443-523
Date Filed 5-15-43

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.