

FILED JUN 14 1943  
258

Registration District No. 258

Primary Registration District No. 4355

Registrar's No. 23

1. PLACE OF DEATH:  
(a) County New Madrid  
(b) City or town New Madrid  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
No. 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 all of life years, months or days)

3. (a) PRINT FULL NAME LEON JONES  
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex M 5. Color or race Black 6. (a) Single, widowed, married, divorced SINGLE  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 29 years (Month) (Day) (Year)  
7. Birth date of deceased Oct 17 - 1941 (Month) (Day) (Year)

8. AGE: Years 1 Months 6 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Child

11. Industry or business \_\_\_\_\_  
12. Name Atlas Jones  
13. Birthplace Richwood, La. (City, town or county) (State or foreign country)  
14. Maiden name Birda Ward  
15. Birthplace Richwood, Tenn. (City, town or county) (State or foreign country)

16. (a) Informant Atlas Jones  
(b) Address New Madrid, Mo.  
17. (a) Burial (b) Date thereof 4-30-43 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Spring Hill  
18. (a) Signature of funeral director Richardson  
(b) Address New Madrid, Mo.  
19. (a) May 7, 1943 (b) White Spider (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County New Madrid  
(c) City or town New Madrid (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 April day 30 year 1943 hour 12.45 minute 9 A.M.  
21. I hereby certify that I attended the deceased from April 29 1943 to April 29, 1943 that I last saw him alive on April 29, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchia Pneumonia  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. L. Diggins (M. D. or other)  
Address New Madrid, Mo. Date signed 5-1-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Office No. 2  
District File Number 643-8a  
Date Filed 6-11-43

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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 Not Embalmed

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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 238

Primary Registration District No. 4255

Registrar's No. 23

**1. PLACE OF DEATH:**  
 (a) County New Madrid  
 (b) City or town New Madrid  
(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 years, months or days)

**3. (a) PRINT FULL NAME** Lear Jones  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color B 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 out 12 1884  
(Month) (Day) (Year)

8. AGE: Years 7 Months 6 Days 12 (if less than one day min.)

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

10. Usual occupation \_\_\_\_\_  
 11. Industry or 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 April year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchitis pneumonia Duration \_\_\_\_\_

Due to No complications

Due to \_\_\_\_\_  
 Other conditions 109  
(Include pregnancy within 3 months of death)

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

**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

S-18499