

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2912

FILED JUL 13 1948
Registration District No. 4079

Primary Registration District No. 1002

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution H E Gen Hospit
(If not in hospital or institution, write street number or location)

(d) Length of stay: 42 hrs
(Specify whether in this community 40 yrs years, months or days) (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ralph Jones

3. (b) If veteran, name war. no

3. (c) Social Security No. none

4. Sex M 5. Color of hair 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 unknown
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>			hr. min.

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

10. Usual occupation none

11. Industry or business

12. Name John Jones

13. Birthplace Miss 1
(City, town, or county) (State or foreign country)

14. Maiden name unknown
(City, town, or county) (State or foreign country)

15. Birthplace Miss 1
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address H E Gen Hospit

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-48
(Month) (Day) (Year)

(c) Place: burial or cremation Local

18. (a) Signature of funeral director Wm A. Brown

(b) Address City

19. (a) 6-30-48 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Manassas City
(If outside city or town limits, write "RURAL")

(d) Street No. 523 Main
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 16 year 1948 hour 10 minute 45

21. I hereby certify that I attended the deceased from 3-10-48 to 4-16-48
that I last saw him alive on 4-16-48, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to cardiac

Due to 107

Other conditions (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? _____

23. Signature Wm R. Brown (M. D. or other)

Address Med Dept H E Gen Hospit Date signed _____

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, fact should be so stated above.