U. S. No. 2
0M—5-42
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

24794

State File No.

FILED AUG 7 19[illegible]

Registration District No. 4196

Primary Registration District No. 5-338-349

Registrar's No. 57

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**1. PLACE OF DEATH:**

(a) County Dallas

(b) City or town Jasper Rural
(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)

In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Dallas

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

(d) Street No. Windxville Mo
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) No

If yes, name country

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3. (a) PRINT FULL NAME Roma Lowell Jones

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S O

6. (b) Name of husband or wife

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

7. Birth date of deceased 2 (Month) 29 (Day) 1916 (Year)

8. AGE: Years 26 Months 11 Days 23 If less than one day hr. min.

9. Birthplace Dallas Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name Lacy Jones

13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

14. Maiden name

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

16. (a) Informant Franklin Jones

(b) Address Windxville Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-43 (Month) (Day) (Year)

(c) Place: burial or cremation Scriven Co Mo.

18. (a) Signature of funeral director L. B. Jones

(b) Address Buffalo Mo.

19. (a) 3/1/43 (Date received local registrar) (b) Helen Dawes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 2 day 23 year 1943 hour 4 minute P M.

21. I hereby certify that I attended the deceased from Jan 1 1943 to Feb 2 1943 that I last saw him alive on 2-22- 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis — Duration 3 yrs

Due to Bacilus Tuberculosis

Due to

Other conditions (Include pregnancy within 3 months of death) 13 fl

Major findings:
Of operations None

Of autopsy No

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 L. B. Thummer (M. D. or other) MD

Address Buffalo Mo Date signed 3-4-43

1181

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 743-747
Date Filed 8-6-43

## 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 Clyde Montgomery

Licensed Embalmer No. 3592

P. O. Address Buffalo Iowa

**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.**