

No. 2
M-2-43
5-17-39
P-1 X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35818

FILED NOV 6 1943

State File No. _____

Registration District No. 316

Primary Registration District No. 6074

Registrar's No. 46

1. PLACE OF DEATH:

(a) County St. Francois

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

(c) Name of hospital or institution: 1 Rural
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community life
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town East Will
(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 Missouri Elizabeth Jones

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct 28 1866
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>86</u>	<u>11</u>	<u>17</u>	hr. _____ min.

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

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name Robert O. Jones

13. Birthplace Tennessee state
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Eaton

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

16. (a) Informant Acie Williams

(b) Address 8. Ethel Mo

17. (a) (Burial, cremation, or removal) _____

(b) Date thereof 10 9-43
(Month) (Day) (Year)

(c) Place: burial or cremation Hopewell Mo

18. (a) Signature of funeral director Shacko and Co

(b) Address Flot Run Mo

19. (a) Oct 15 1943 (b) Lyndie Burkmaster
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9 year 43 hour 3:30 minute A.M.

21. I hereby certify that I attended the deceased from June 1943 to Oct 9 1943
that I last saw her alive on Oct 8 1943
and that death occurred on the date and hour stated above.

Immediate cause of death broncho-pneumonia

Duration 5 day

Due to _____

Due to _____

Other conditions Arterio Sclerosis
(Include pregnancy within 3 months of death)

Major findings: 12 ft

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 [Signature] (M. D. or other) _____

Address St. Louis MO Date signed 10-14-43

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

Health Officer No. ⁴
District File Number 1143-2871
Date Filed 11-5-43

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 Ernest Sparks

Licensed Embalmer No. 71287

P. O. Address Flat River Mo

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.