

No. 2
1-4-41
117-30
X24931

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35928**

Registration District No. **1942333**

Primary Registration District No. **3074**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott Co.

(b) City or town Sikeston, Missouri
(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 _____
In this community _____ 36 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scott ¹⁰⁰ ₅

(c) City or town Sikeston, Mo
(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 _____ 0

3. (a) PRINT FULL NAME Thomas Westley Jones

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9 ^{or} _P
year 1947 hour 8 minute _____ M.

21. I hereby certify that I attended the deceased from March 1 1947 to March 9 1947
that I last saw him alive on 3-8 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or Race W 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased Sept 28 1854
(Month) (Day) (Year)

Immediate cause of death myocarditis

Due to _____

Due to _____

8. AGE: Years Months Days If less than one day

88 5 7 _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) 93e1

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

9. Birthplace Johnson Co. Ill
(City, town or county) (State or foreign country)

10. Usual occupation Saw Mill Operator

11. Industry or business _____

12. Name Thomas W. Jones

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

14. Maiden name AMANDA SIMPSON

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

16. (a) Informant W. O. Scott

(b) Address Sikeston, Mo.

17. (a) Burial (Burial, cremation or removal) (b) Date thereof MARCH 10-1947
(Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

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) (c) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Sikeston Mo Date signed 9-4-47

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

10
5
2

RECEIVED

District Health Office No. 2,

District File Number 1043-1298

Date Filed 10-15-43

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 Maud

~~_____~~, Registered Apprentice No. _____,
working under my personal supervision.

Signed Arthur Ellis

Licensed Embalmer No. 4218

P. O. Address St. Louis, 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.