

No. 2  
1-2-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38718**  
Registrar's No. **89**

**D DEC 9 1943**  
Registration District No. **217**

Primary Registration District No. **3045**

1. PLACE OF DEATH:  
(a) County **MISSISSIPPI**  
(b) City or town **CHARLESTON**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**W. N. ELM.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether  
In this community **24 YRS** (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **MISSOURI** (b) County **MISSISSIPPI**  
(c) City or town **CHARLESTON**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **101 W. ELM.**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country **-**

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **11** day **7**  
year **1943** hour **11** minute **30 P.M.**  
21. I hereby certify that I attended the deceased from **July**  
**1943**, to **Nov.**, 1943;  
that I last saw him alive on **11-5-43**, 1943;  
and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or Race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**  
6. (b) Name of husband or wife **MIKA JONES** 6. (c) Age of husband or wife if alive **72** years  
7. Birth date of deceased **MARCH 1 1869**  
(Month) (Day) (Year)

Immediate cause of death **Hypertension**  
**Cardiovascular**  
Duration **Don't Know**

8. AGE: Years **74** Months **8** Days **6** If less than one day hr. min.

Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations  
Of autopsy

9. Birthplace **POPK COUNTY ILL.**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **RETIRED BLACK SMITH**  
11. Industry or business  
12. Name **JOHN R. JONES**  
13. Birthplace **POPK CO. ILL.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **KATE MORRIS**  
15. Birthplace **POPK CO. ILL.**  
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Allie JONES**  
(b) Address **209 Cleveland - CHARLESTON, MO.**  
17. (a) **BURIAL** (b) Date thereof **11-9-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **DAK GROVE CEMETERY CHARLESTON**  
18. (a) Signature of funeral director **W. H. ...**  
(b) Address **177 1/2 ...**  
19. (a) **11/1/43** (b) **Mrs. Lon Moore**  
(Date received local registrar) (Registrar's signature)

23. Signature **E. C. Greenell** (M. D. or other) **M. D.**  
Address **Charleston, Mo.** Date signed **11-8-43**

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 1243-154

Date Filed 12-8-43

**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 John F. Rimmeler Jr  
.....  
Licensed Embalmer No. 3851

P. O. Address Charleston, 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.**