

FILED JAN 6 1948

Registration District No. **300**

Primary Registration District No. **6074**

Registrar's No. **49**

1. PLACE OF DEATH

(a) County **St. Francois Co.**
(b) City or town **Eastwell**
(c) Name of hospital or institution: **Rural 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: **4 1/2 years** (Specify whether years, months or days)
In this community **4 1/2 years**

3. (a) PRINT FULL NAME **William Thomas Jones**

3. (b) If veteran name war **—** 3. (c) Social Security No. **498-104124**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
(b) Name of husband or wife **Minnie Jones** 6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **Nov 9 1868**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	75	1	7	hr. min.

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

10. Usual occupation **Diamond Drill operator**

11. Industry or business **St. Joseph Lead Co.**

FATHER { 12. Name **William Thomas Jones**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name **Menerve Patton**
15. Birthplace **Washington Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Raymond Jones**

(b) Address **Elwin Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **12-19-48**
(Month) (Day) (Year)

(c) Place: burial or cremation **Good Cemetery Heloga Mo**

18. (a) Signature of funeral director **Charles W. C.**

(b) Address **Flat 2, Elwin Mo**

19. (a) **Dec. 23 1948** (Date received local registrar) **Lyndie Burkmaster** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Francois**
(c) City or town **Eastwell**
(If outside city or town limits, write "RURAL")
(d) Street No. **Rural**
(If rural, give location)
(e) Citizen of foreign country? **—** (Yes or No)
If yes, name country **—**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** Day **16** year **43** hour **3 P** minute **AM**

21. I hereby certify that I attended the deceased from **Dec 15** to **Dec 16**, 19**43**
that I last saw him alive on **Dec 15**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumo-pneumonia** Duration **3d**
Due to **Intra-cranial hemorrhage** **10d**
Due to **arteriosclerosis general**

Other conditions (include pregnancy within 3 months of death)
Major findings: **g3a!**
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) Means of injury
23. Signature **J. P. Gable** (M. D. or other)
Address **Heloga Mo** Date signed **12-18-48**

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

RECEIVED

District Health Officer No. 4
District File Number 144-3121
Date Filed 1-5-44

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 Everett Sparks

Licensed Embalmer No. 4287

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.