

FILL FEB 4 1944
Registration District No. _____

Primary Registration District No. 3017

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

1. PLACE OF DEATH:

(a) County Cooper County

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

(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 hrs.
In this community 9-hrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 45

(a) State Mo (b) County Howard

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

(d) Street No. 6th St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

8. (a) PRINT FULL NAME Amy Beatrice Chadwick Jones

8. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1
year 1944 hour 5 minute 20 A. M.

21. I hereby certify that I attended the deceased from 12-21
1943, to 1-1, 1944
that I last saw her alive on 1-1, 1944
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single (widowed, married, divorced, Mar)

6. (b) Name of husband or wife W.C. Jones 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased 6-11-1892
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration 9 hrs

8. AGE: Years 51 Months 6 Days 21 If less than one day _____ hr. _____ min.

Due to Hypertension

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

Due to _____

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business _____

12. Name Milton Chadwick

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

14. Maiden name Bessie Owens Chadwick

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

Major findings: _____

Of operations: _____

Of autopsy: _____

PHYSICIAN [Signature]
Underline the cause to which death should be charged statistically.

16. (a) Informant W.C. Jones

(b) Address Glasgow Mo

17. (a) Removal (b) Date thereof 1-1-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Glasgow, Mo.

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? _____

18. (a) Signature of funeral director [Signature]

(b) Address Glasgow Mo

19. (a) Jan-4-44 (b) Dr. Chas. Swap
(Date received local registrar) (Registrar's signature)

While at work _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Glasgow, Mo Date signed 1-1-44

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2-2-44

FILED 20 1950

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

E. W. Frimouth

Licensed Embalmer No. 3978

P. O. Address Glasgow 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, above space should be left blank.