

FILED FEB 7 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 5391

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Dent  
(b) City or town Texas  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: X  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution X (Specify whether years, months or days) most of his life

3. (a) PRINT FULL NAME Cassius E Jones

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

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

6. (b) Name of husband or wife Elizabeth Ann Jones 6. (c) Age of husband or wife if alive, years \_\_\_\_\_

7. Birth date of deceased July 26 1857  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
86 5 17 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation farmer

11. Industry or business X

12. Name Michael Jones  
13. Birthplace Tenn. (City, town, or county) (State or foreign country)

14. Maiden name Nancy Hunt  
15. Birthplace N. Carolina (City, town, or county) (State or foreign country)

16. (a) Informant Herbert L Jones  
(b) Address Rhyse Mo

17. (a) Burial (b) Date thereof 1/16/44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Herman Cem

18. (a) Signature of funeral director Carl K. Spurr  
(b) Address Salem Mo

19. (a) 1-15-44 (b) James D. McCord by Mrs  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13  
year 1944 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from Dec 2/44 to Jan 10/44  
that I last saw him alive on Jan 10/44  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Bronchitis

Due to 93d

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

Major findings: Stenosis  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (a) Means of injury \_\_\_\_\_

23. Signature J. D. Spurr (M. D. or other)  
Address Salem Mo Date signed 1/13/44

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

MOTHER FATHER

Physician  
5 da.  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number

24491  
2-4-44

Date Filed

FEB 8 1955

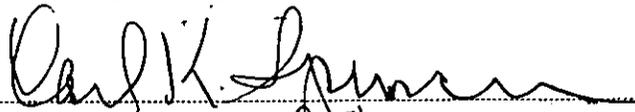
STATEMENT BY LICENSED EMBALMER

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.....

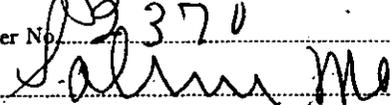
working under my personal supervision.

Signed.....



Licensed Embalmer No. 370

P. O. Address.....



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.