

FILED MAR 15 1944

Registration District No. 41

Primary Registration District No. 3008

Registrar's No.

1. PLACE OF DEATH:
 (a) County Callaway
 (b) City or town Fulton Mo
 (c) Name of hospital or institution State Hospital No. 1 2
 (d) Length of stay: In hospital or institution 4 yrs 9m 8d
 In this community 4 yrs 9m 8d

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Gasconade
 (c) City or town Rosetown
 (d) Street No. _____
 (e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Charles Jones
 3. (b) If veteran, name war DK
 3. (c) Social Security No. DK

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb day 3
 year 1944 hour 5-25 minute P M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Merle Mabry Jones
 6. (c) Age of husband or wife if alive Deceased
 7. Birth date of deceased (Month) Dec (Day) 23 (Year) 1883

21. I hereby certify that I attended the deceased from 1-15, 1944, to 2-3, 1944
 that I last saw him alive on 2-3, 1944
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

8. AGE: Years 60 Months 1 Days 10
 If less than one day hr. _____ min. _____

Due to Myocarditis
Paresis

9. Birthplace Phelps County Mo

Due to _____

10. Usual occupation Laborer

Other conditions _____

11. Industry or business Timber

Major findings: _____

12. Name James Jones

Of operations _____

13. Birthplace Mo

Of autopsy _____

14. Maiden name Sally Jackson

22. If death was due to external causes, fill in the following:

15. Birthplace Mo

(a) Accident, suicide, or homicide (specify) _____

16. (a) Informant Record

(b) Date of occurrence _____

17. (a) Removal (b) Date thereof 2 5 44

(c) Where did injury occur? _____

18. (a) Signature of funeral director Columbia Mo

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(b) Address Columbia Mo

While at work _____ (e) Means of injury _____

19. (a) Feb 5 1944 (b) Joie Morrison

23. Signature George H. Neers (M. D. or other) MA

(Date received local registrar) _____ (Registrar's signature) _____

Address Fulton Mo Date signed 2-3

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

MOTHER FATHER

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

308

114

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 3-14-44

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.....

Licensed Embalmer No.....

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.