

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

41
39
26390

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

8538

State File No. _____

FILED MAR 14 1944

Registration District No. 337

Primary Registration District No. 61-0

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County STODDARD, NEW LISBON TWP.
 (b) City or town BARABE
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 4 wks 4 days (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County BEHNINGER
 (c) City or town RURAL
NEAR LUTESVILLE (If outside city or town limits, write "RURAL")
 (d) ~~State~~ LUTESVILLE (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MARY ANN JONES
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife JOHN FRANKLIN JONES 6. (c) Age of husband or wife if alive 70 years
 7. Birth date of deceased MAY 17 1877
 (Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace REYNOLDSBURG ILL.
 (City, town, or county) (State or foreign country)

10. Usual occupation H.W.F.

11. Industry or business _____

MOTHER FATHER
 12. Name ELISHA REYNOLDS
 13. Birthplace REYNOLDSBURG ILL.
 (City, town, or county) (State or foreign country)
 14. Maiden name NANCY TRAEGLSTEAD
 15. Birthplace REYNOLDSBURG ILL.
 (City, town, or county) (State or foreign country)

16. (a) Informant MRS CHARLIE DUNN
 (b) Address LUTESVILLE, MO.
 17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 29 1944
 (Month) (Day) (Year)
 (c) Place: burial or cremation DRY CREEK CEM.

18. (a) Signature of funeral director DAKER FUNERAL HOME
 (b) Address LUTESVILLE, MO. 2 E. Main
Feb. 5th 1944
 19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month JAN. day 28
 year 1944 hour 9:00 minute 45 A. M.
 21. I hereby certify that I attended the deceased from 1/10/44
 _____, 19____, to 1/28/44, 19____
 that I last saw h. alive on 1/28/44, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
 Due to secondary to influenza
 Due to _____

Other conditions (Include pregnancy within 3 months of death) 37a

Major findings:
 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)
 (e) Means of injury 9

23. Signature John H. Myers M.D. (M. D. or other)
 Address Lutesville, Mo. Date signed 2/3/44

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

RECEIVED

District Health Office No. 2

District File Number 344-451

Date Filed 3-9-44

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 J. E. Graham

Licensed Embalmer No. 4010

P. O. Address Lutesville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 239

Primary Registration District No. 6150

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard
(b) City Rural New Liberty Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Mary Ann Jones

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 17
(Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days _____ Unless than one day _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

MOTHER FATHER

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 3/15/1944 (b) (J. M. Stummer)
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year 1944 minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____
Due to _____

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

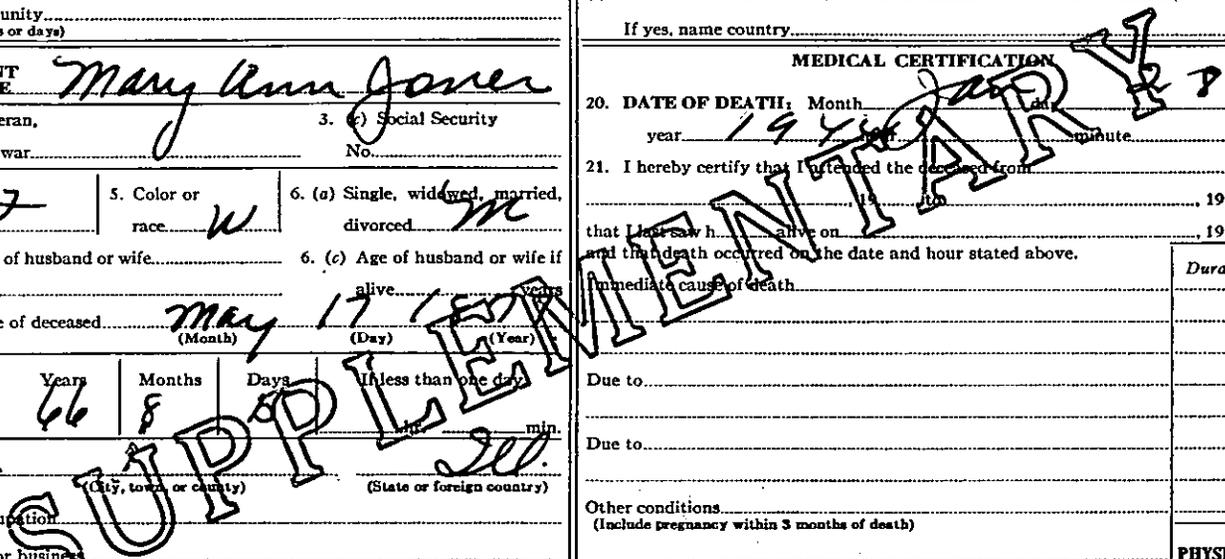
Major findings:
Of operations _____
Of autopsy _____

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____



APR 7 1947

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APR 3 1947