

FILED JUL 20 1944
Registration District No. 178

Primary Registration District No. 4283

State File No. _____

Registrar's No. 63

1. PLACE OF DEATH:
(a) County Lewis
(b) City or town Lewising
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 2 yrs years, months or days

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

3. (a) PRINT FULL NAME Robert Lee Jones
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 11
year 1944 hour 1:45 minute _____ P.M.
21. I hereby certify that I attended the deceased from JUNE 2
1944 to JUNE 11 1944
that I last saw him alive on JUNE 2 1944
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W.
6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Ida Mae Jones 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased Oct 25 1870
(Month) (Day) (Year)

Immediate cause of death APOPLEXY
Due to HYPERTENSION & NEPHRITIS
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years 73 Months 7 Days 16 If less than one day _____ hr. _____ min.
9. Birthplace Maywood, MO
(City, town, or county) (State of foreign country)
10. Usual occupation F. Farmer

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? _____
(Specify type of place)
While at work? _____ (e) Means of injury _____

MOTHER FATHER
11. Industry or business _____
12. Name Joseph Jones
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Adeline Jones
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

23. Signature W. F. Ellen M.D. (M. D. or other)
Address Leasange MO Date signed 6/13/44

16. (a) Informant Era Lee Hestell
(b) Address Maywood MO
17. (a) Burial (b) Date thereof June 12 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Flower Cemetery A.H. Chambers
18. (a) Signature of funeral director A.H. Chambers
(b) Address Maywood MO
19. (a) 6/12/44 (b) P.W. Jennings
(Date received local registrar) (Registrar's signature)

Handwritten notes and scribbles at the top of the page, including the word "around" on the left and "M" on the right.

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 *A. N. Chambers*
Licensed Embalmer No. *3760*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug
Registrar's No. 638

Registration District No. 178

Primary Registration District No. 4283

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Cuning
(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)

3. (a) PRINT FULL NAME

Robert Lee Jones

3. (b) If veteran, name war.....

3. (c) Social Security No. Mo

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

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

7. Birth date of deceased Oct 25 (Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 2 If less than one day..... min.

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation
18. (a) Signature of funeral director.....
(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... year 1946 hour..... minute..... M.
21. I hereby certify that I attended the deceased from....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death apoplexy Duration

Due to hypertension nephritis CHRONIC
Due to PYORRHEIC ALVEOLARIS
Other conditions..... (include pregnancy within 3 months of death)

Major findings: Of operations.....
Of autopsy.....
1318
PHYSICIAN

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 W. S. May (M. D. or other)
Address..... Date signed.....

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