

FILED SEP 14 1944

Registration District No. **2001**

Registrar's No. **412**

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

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Joplin**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Freeman Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 week**
In this community **10 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Dr. Harvey Alexander Jones**

3. (b) If veteran, name war **none**
3. (c) Social Security No. **none**

4. Sex **male**
5. Color or race **white**
6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Martha A. Jones**
6. (c) Age of husband or wife if alive **----** years
7. Birth date of deceased **August 3 1864**
(Month) (Day) (Year)

8. AGE: Years **80** Months **0** Days **19**
If less than one day hr. min.

9. Birthplace **Sedalia Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **retired minister**

11. Industry or business -----

MOTHER FATHER
12. Name **Benjamin Jones**
13. Birthplace **unknown Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Helen Jones**
(b) Address **726 W. Chestnut, Carthage, Mo**

17. (a) **Burial**
(Burial, cremation, or removal) (b) Date thereof **Aug 24, 1944**
(Month) (Day) (Year)

(c) Place: burial or cremation **Park Cemetery**

18. (a) Signature of funeral director **Knell Mortuary Carthage, Missouri**
(b) Address

19. (a) **8-24-44** (b) **Justinus Redhauber**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper**
(c) City or town **Carthage**
(If outside city or town limits, write "RURAL")
(d) Street No. **726 W. Chestnut St.**
(If rural, give location)
(e) Citizen of foreign country? **No**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **22**
year **1944** hour **8** minute **a** M.

21. I hereby certify that I attended the deceased from **12-29-41**, 19____ to **8-22-44**, 19____;
that I last saw him alive on **8-22-44**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death

Chronic myocarditis with **10 yrs.**
Due to Candida Dieatation

Due to Hypertens wn **10 yrs**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **938**
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) (c) Means of injury _____

23. Signature **Walter H. ...** (M. D. or other)
Address **Joplin Mo** Date signed **8/24/44**

44-2116

1 311 14 1972

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..... *Emmal Street*

Licensed Embalmer No. *391*

P. O. Address..... *Carthage*

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.