

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

37496

State File No. \_\_\_\_\_

FILED NOV 28 1944  
 Registration District No. \_\_\_\_\_

Primary Registration District No. 5289

Registrar's No. 109

1. PLACE OF DEATH:  
 (a) County Clay  
 (b) City or town Gashland Rural Pte. 1  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1  
(Specify whether years, months or days)  
 In this community 15 years

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Clay  
 (c) City or town Gashland Mo Rural Pte 1  
(If outside city of town limits, write "RURAL")  
 (d) Street No. Pte #1  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME DANIEL NOBEL JONES  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Nov day 9  
 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from Oct 4  
 \_\_\_\_\_, 1944, to Nov 9, 1944  
 that I last saw him alive on Nov 8, 1944  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife MAUDE JONES  
 6. (c) Age of husband or wife if alive 80 years  
 7. Birth date of deceased March 31 1862  
(Month) (Day) (Year)

Immediate cause of death Myocarditis Chronic Atherosclerosis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

8. AGE: Years 82 Months 7 Days 9  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: g3d  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

9. Birthplace Indiana  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Bridge Construction

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 \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 12. Name Jim Jones  
 13. Birthplace Indiana  
(City, town, or county) (State or foreign country)  
 14. Maiden name Martha Nobel  
 15. Birthplace Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Maude Jones  
 (b) Address Gashland Mo Pte #1  
 17. (a) Burial (b) Date thereof Nov 11 44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Liberty Mo

23. Signature Samuel Hodges (M. D. or other) \_\_\_\_\_  
 Address North Kansas Date signed 11/9/44

18. (a) Signature of funeral director Morton Funeral Home  
 (b) Address Mo  
 19. (a) Nov 10 1944 (b) Rich W Henry  
(Date received local registrar) (Registrar's signature)

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

2400

MOTHER FATHER

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 11-25-47

**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 \_\_\_\_\_

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed \_\_\_\_\_

Licensed Embalmer No. 349

P. O. Address no 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.**