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M-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42245

State File No. _____

FILED DEC 31 1944

Registration District No. _____

Primary Registration District No. 6128

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Nut Crunch (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sulphur
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon 101
(c) City or town Nut Crunch (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

Mrs. Joshua Jones

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12
year 1944 hour 10 minute P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy

Duration _____

4. Sex M 5. Color or race A 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Sarah C. Jones 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Mar 29 1878 (Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation Cornur

11. Industry or business _____

MOTHER FATHER { 12. Name Kenny C. Jones
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name Emma Chilton
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant Frank Jones
(b) Address W. E. No

17. (a) Burial (b) Date thereof 12-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Chapel

18. (a) Signature of funeral director J. F. Duveau
(b) Address MT. Vernon Mo

19. (a) 12-13-44 (b) Frank Hyde Mo
(Date received local registrar) (Registrar's signature)

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 Frank Hyde (M. D. or other) _____
Address Crunch Date signed 12-14-44

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

Date Filed _____
File Number _____
District Health Officer No. 5,

RECEIVED
District Health Officer No. 5,
File Number 1244619
dated 12-19-44

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 John F. Armean
Licensed Embalmer No. 2516
P. O. Address Montevideo, Mo

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.