

FILED APR 26 1945  
Registration District No. 2043

Primary Registration District No. 2043

Registrar's No. 80

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

1. PLACE OF DEATH: Marion

(a) County Marion

(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1202 Colfax  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 1 mo. 6 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

(c) City or town Hannibal  
(If outside city or town limits, write "RURAL")

(d) Street No. 1202 Colfax  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Gola Ray Jones

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 7  
year 1945 hour 9:02 minute A. M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married. Divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased. Jan. 1 1945  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from  
Feb 6, 1945 to Feb 7, 1945  
that I last saw him alive on Feb 7, 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
0 1 6 hr. \_\_\_\_\_ min.

Immediate cause of death Bronchial Pneumonia Duration 5 day

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

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Gola Roscoe Jones

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

14. Maiden name Sarahy Oliver

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

16. (a) Informant Gola Roscoe Jones

(b) Address 1202 Colfax Ave. Hannibal, Mo.

17. (a) Burial (b) Date thereof 2-8-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet

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? \_\_\_\_\_

18. (a) Signature of funeral director Ray P. Schwartz

(b) Address Hannibal, Mo.

19. (a) 3/16/45 (b) M. W. Connor  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Green R. Miller (M. D. or other) MD  
Address Hannibal, Mo. Date signed 3/16/45

**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 Paul H. Jenkins  
Licensed Embalmer No. 4110  
P. O. Address Winnfield, 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.**