

FILED JUN 5 1945

Registration District No. _____

Primary Registration District No. 3390

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Dent

(b) City or town Spring Creek Township Rural
(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 years, months or days)

In this community 64 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dent

(c) City or town Rural - Spring Creek - Township
(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 Maggie Ester Jones.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18 year 1945 hour 12 minute noon

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced M.

6. (b) Name of husband or wife Phil Jones. 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Feb 4 1881
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-27-45 19. to 5-18-45 19. ; that I last saw h. EC alive on 4-15-45 19. ; and that death occurred on the date and hour stated above.

8. AGE: Years 64 Months 3 Days 14 If less than one day hr. _____ min. _____

Immediate cause of death Cerebral hemorrhage

Due to " " stroke

Duration ?

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

10. Usual occupation Housekeeper

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations Hb

Of autopsy _____

MOTHER FATHER

11. Industry or business _____

12. Name W. F. Golden

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

14. Maiden name Mary Supton

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Phil Jones

(b) Address Salem, Mo.

17. (a) Burial (b) Date thereof 5-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Grove

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 Hobson & Sheahan

(b) Address Salem, Mo.

19. (a) 5-19-45 (b) J. S. [Signature]
(Date received local registrar) (Registrar's signature)

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

23. Signature J. S. [Signature] (M. D. or other) D.D.

Address Salem, Mo. Date signed 5-18-45

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

RECEIVED

District Health Officer No. 5,

District File Number 645.249

Date Filed 6.4.45-

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.....

me....., Registered Apprentice No.....
working under my personal supervision.

Signed Oral E. Kiebler

Licensed Embalmer No. 3546

P. O. Address St. James 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.