S. No. 2
M—5-42
5-17-39
P I X32873

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

27389

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 29 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 630

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution:
I53I E Central
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 7 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County DADE

(c) City or town ~~xSpringfield~~ Rural
(If outside city or town limits, write "RURAL")
Everton

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

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Thomas Allen Jones

3. (b) If veteran, name war Unk.

3. (c) Social Security No. Unk.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jesse May Jones

6. (c) Age of husband or wife if alive Unk. years

7. Birth date of deceased June (Month) 26, (Day) 1869 (Year)

8. AGE: Years 76 Months 1 Days 16 If less than one day ..... hr. ..... min.

9. Birthplace ~~Illinous~~ Unk. (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Labore R

11. Industry or business .....

FATHER
12. Name ~~xxxx~~ xxx ~~xxxxxx~~
13. Birthplace Unk. (City, town, or county) Unk. (State or foreign country)

MOTHER
14. Maiden name Sarah Fletcher
15. Birthplace ~~xxxxxx~~ xx xxxx Unk. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Homer Jones
(b) Address Everton, Mo.

17. (a) ~~Eastlawn~~ Bura (Burial, cremation, or removal) (b) Date thereof 8-15-45 (Month) (Day) (Year)
(c) Place: burial or cremation Eastlawn

18. (a) Signature of funeral director Fred C. Phieme
(b) Address Springfield, Mo

19. (a) 8-14-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12
year 1945 hour 11 minute 50 P M.

21. I hereby certify that I attended the deceased from July 15th, 1945, to Aug 12, 1945
that I last saw him alive on Aug 11, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of Prostate	2 yr.
Due to	
Due to	
Other conditions Cardio-Renal-Vascular (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?
(Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature [signature] (M. D. or other) M.D.

Address Springfield Mo Date signed 8-13-45

(Licensed Embalmer's Statement on Reverse Side)

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 Fred C. Friemo

Licensed Embalmer No. 2899

P.O. Address Springfield, 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.