

S. No. 2  
I-8-43  
5-17-39  
PI X37823

DEPARTMENT OF COMMERCE

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27800

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

FILED SEP 7 1945

Registration District No. 179

Primary Registration District No. 4287

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Lucas

(b) City or town Troy  
(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 \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lucas

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

(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 Tollie C. Jones

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug, day 9, year 1945 hour 2 minute 45 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 1945 to \_\_\_\_\_ 1945

4. Sex male 5. Color or race white 6. (a) ~~Single, widowed, married, divorced, married~~

6. (b) Name of husband or wife Dollie Jones 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased February 18, 1872  
(Month) (Day) (Year)

that I last saw him alive on Aug 9, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy Duration 1 hr

8. AGE: Years 73 Months 4 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

Due to Arterio-sclerosis

Due to Diabetes Mellitus

10. Usual occupation Retired stock man

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

MOTHER FATHER { 12. Name Elihu Jones

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

14. Maiden name Mary Miller Jones

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

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

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

Of autopsy Col

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

16. (a) Informant Mrs Emmett Haisell

(b) Address Troy, Mo

17. (a) Burial (b) Date thereof Aug 11, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Troy City Cemetery

18. (a) Signature of funeral director Kentper Funeral Home

(b) Address Troy, Mo

19. (a) Aug 18, 1945 (b) Pauline D. Grogan  
(Date recorded local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

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

23. Signature J. C. ... (M.D. or other) \_\_\_\_\_

Address Troy, Mo Date Aug 12/45

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed.....

9-6-45

DEC 20 1945

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.....

Licensed Embalmer No.....

P. O. 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.