

S. No. 2
OM-8-43
v. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
1945
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28691

State File No. _____

Registration District No. 338

Primary Registration District No. 6148

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Bloomfield, Star Rt. ^{Caater}
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None
(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
years, months or days

3. (a) PRINT FULL NAME JOSEPH S. JONES

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

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Agnes Jones

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

7. Birth date of deceased May 28, 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>1</u>	<u>26</u>	<u>min.</u>

9. Birthplace Stoddard co. Mo. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Jim Jones

13. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

14. Maiden name Maggie Tucker

15. Birthplace 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Agnes Jones

(b) Address Bloomfield, Mo. R # 1

17. (a) Burial (b) Date thereof July 26-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Grove cem. Chiles Und. Co.

18. (a) Signature of funeral director _____

(b) Address Bloomfield, Mo.

19. (a) 8-17-45 (b) Pearl Elmore
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard 10

(c) City or town Bloomfield, Star Route # 1
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24th
year 1945 hour 4:10 minute A. M.

21. I hereby certify that I attended the deceased from 6-20, 1945 to 7-24, 1945
that I last saw him alive on 7-24, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE 2 wks

Duration _____

Due to ARTERIO SCLEROSIS

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 43
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? _____ (Specify type of place) _____
Means of injury ?

23. Signature P. S. Lawrence (M.D.)
Address BLOOMFIELD Date signed 7-27-45

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

1130

RECEIVED

District Health Office No. 2,

District File Number 945-299

Date Filed 9-6-45



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 Loren C. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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.