30669

S. No. 2
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v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 22 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 91

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

1. PLACE OF DEATH:
(a) County Howell Co
(b) City or town West Plains, Mo
(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 Howell 46
(c) City or town West Plains Mo /
(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 James R. Jones
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓
4. Sex Mo 5. Color or race W 6. (a) Single, widowed, married, divorced M /
6. (b) Name of husband or wife Laura B. Jones 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased 4 (Month) 18 (Day) 1859 (Year)

8. AGE: Years 86 Months 4 Days If less than one day hr. min.

9. Birthplace Tennessee (City, town, or county) / (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Unk. Jones
13. Birthplace (City, town, or county) Tennessee (State or foreign country)
MOTHER 14. Maiden name Margaret Unk
15. Birthplace Unk (City, town, or county) Ky / (State or foreign country)
16. (a) Informant Mrs. Jas. R Jones
(b) Address West Plains, Mo Rt 3.
17. (a) B (Burial, cremation, or removal) (b) Date thereof 8-19-45 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope
18. (a) Signature of funeral director Robertson
(b) Address West Plains Mo
19. (a) 8-20-45 (Date received local registrar) (b) Jack Hailey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 17 year 1945 hour 2 minute 15 M.
21. I hereby certify that I attended the deceased from Aug. 12, 1945 to Aug. 17, 1945 that I last saw him alive on Aug. 12, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Progressive muscular Atrophy.	2 yrs.
Due to Undetermined	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 156 N	
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 A H Thornburgh (M. D. or other)
Address West Plains, Mo Date signed 8/17/45

1820

(Licensed Embalmer's Statement on Reverse Side) Thornburgh

RECEIVED
District Health Officer No. 5,
District File Number 945-389
Date Filed 9-21-45.

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.....

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.