

1-2-43
-17-39
X35697

FILED JAN 26 1946
128

Registration District No. _____

Primary Registration District No. **2000**

Registrar's No. **35**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Springfield Baptist Hospital**
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution **1 day**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lawrence**
(c) City or town **North Vernon**
(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 **William Peter Jones**

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

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Clara Jones**
6. (c) Age of husband or wife if alive **66** years

7. Birth date of deceased **Feb. 14 1870**
(Month) (Day) (Year)

8. AGE: Years **75** Months **10** Days **28**
If less than one day hr. min.

9. Birthplace **North Vernon, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retail Farmer**

11. Industry or business **Agriculture & Dairy**

12. Name **John David Jones**

13. Birthplace **North Vernon, Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Genevieve Roberts**

15. Birthplace **Unk. Texas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Little Book - Unk.**

(b) Address **Chas E. Jones**

17. (a) **Burial** (b) Date thereat **July 14 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Roberts Cemetery**

18. (a) Signature of funeral director **Geo. B. Orr**

(b) Address **North Vernon, Mo.**

19. (a) **1-15-46** (b) **W. E. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **12**
year **1946** hour **10:10** minute **am**

21. I hereby certify that I attended the deceased from **11/11/46**
..... 19..... to 19.....

that I last saw him alive on **11/11** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**

Duration **1 wk**

Due to.....

Due to.....

Other conditions **Chronic Myocarditis 2 yr**
(Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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?

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

23. Signature **Ray C. Callaway** (M. D. or other) **MD**
Address **Springfield, Mo.** Date signed **1/15/46**

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

044

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STATE

EMBAL

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 *George B. Crew*.....

Licensed Embalmer No. *946*.....

P. O. Address *74th Vernon, 7th*.....

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.

X

Registration District No. 138 Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(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 _____ (b) County _____

(c) City or town _____
(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 William P. Jones

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Feb 1946
(Month) (Day) (Year)

8. AGE: Years 75 Months _____ Days _____ (If less than one day, hr. _____ min. _____)

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____
(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 12 Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Broncho. Pneumonia

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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? _____

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

23. Signature Ray Hallaway (M. D. or other) _____
Address Springfield Mo Date signed _____

SUPPLEMENTARY

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

2716