

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4416**
Registrar's No. **5**

FILED FEB 15 1946
Registration District No. **6276**

Primary Registration District No. **6276**

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME

Mary Ella Jones

3. (b) If veteran, name war

3. (c) Social Security No. **1**

4. Sex **7.1**

5. Color or race **W**

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

6. (b) Name of husband or wife

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

7. Birth date of deceased **out** (Month)

6 (Day) **1961** (Year)

8. AGE:

Years **84** Months **20** Days **25**

If less than one day hr. min.

9. Birthplace

Madison (City, town, or county)

MO. (State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

12. Name

Jerry Higgs

13. Birthplace

Union (City, town, or county)

Indiana (State or foreign country)

14. Maiden name

Evelyn Allison

15. Birthplace

Union (City, town, or county)

Indiana (State or foreign country)

16. (a) Informant

Arnell Jones

(b) Address

Sherridan, Mo.

17. (a)

Sherridan (Burial, cremation, or removal)

(b) Date thereof

1-3-46 (Month) (Day) (Year)

(c) Place: burial or cremation

Madison Cemetery

18. (a) Signature of funeral director

Wm. C. Duff

(b) Address

Sherridan, Mo.

19. (a)

Jan 7-1946 (Date received local registrar)

(b) **Letha E. Dawson** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **North**
(c) City or town **Sherridan** (If outside city or town limits, write "RURAL")
(d) Street No. **Sherridan** (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **31**
year **1945** hour **10** minute **30** P. M.

21. I hereby certify that I attended the deceased from

Dec. 30 1945

that I last saw him alive on

Duration

and that death occurred on the date and hour stated above.

Immediate cause of death

Old Age
Diabetic Angrene **3 wks**

Due to

Due to

Other conditions

(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?

While at work?

(Specify type of place)

(c) Means of injury

23. Signature **Bentley Neal** (M. D. or other) **D.O.**

Address **Sherridan, Mo.** Date signed **1/2/46**

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.