

STANDARD CERTIFICATE OF DEATH

State File No. **17200**

Registration District No. **176**

Primary Registration District No. **5-6-5-4 4278**

Registrar's No. **20**

1. PLACE OF DEATH:

(a) County **Lawrence**
 (b) City or town **Miller**
 (c) Name of hospital or institution: **Residence 1**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7**
 (Specify whether
 In this community **Native**
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lawrence**
 (c) City or town **Miller**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **0**
 (If rural, give location) **0**
 (e) Citizen of foreign country? **-** (Yes or No)
 If yes, name country **-**

3. (a) PRINT FULL NAME **Dr. Francis Jones**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **10010**

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

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

7. Birth date of deceased **10 - 3 - 1890**
 (Month) (Day) (Year)

8. AGE: Years **55** Months **6** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **Lawrence Co. Mo. a**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Interior Decorator**

11. Industry or business _____
 12. Name **John Jones**

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

14. Maiden name **Margaret Greeson**
 15. Birthplace **Lawrence Co. Mo. b**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Nora Brown**
 (b) Address **Miller Mo.**

17. (a) **Buried** (b) Date thereof **4-14-1946**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Pleasant Grove**

18. (a) Signature of funeral director **Monroe - Lemmon**
 (b) Address **Miller Mo.**

19. (a) **4-17-46** (b) **H. S. Burney**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **14**
 year **1946** hour **6** minute **15** P. M.
 21. I hereby certify that I attended the deceased from **April 11**
 19**46** to **April 14** 19**46**
 that I last saw him alive on **April 12** 19**46**
 and that death occurred on the day and hour stated above.

Immediate cause of death **Acute Nephritis**
 Duration _____

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
 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)
 (e) Means of injury _____

23. Signature **H. S. Burney** (M. D. certifier)
 Address **Miller Mo.** Date signed **4/17/46**

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

RECEIVED

District Health Officer No. 6,

District File Number 546-584

Date Filed MAY 15 1946

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 J. R. Seaman

Licensed Embalmer No. 3297

P. O. Address Miller M.

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.

Registration District No. 176

Primary Registration District No. 4278

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Lawrence
 (b) City or town Miller
(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)

3. (a) PRINT FULL NAME

Ora F. 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 yes
 6. (b) Name of husband or wife Etha Jones 6. (c) Age of husband or wife if alive 58 years
 Birth date of deceased Oct 3
(Month) (Day) (Year)

8. AGE: Years 55 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 _____

MOTHER FATHER } 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) W. S. Burney
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ 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 _____
 Duration _____

Due to alcoholism
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death) ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 Major findings: Of operations _____
 Of autopsy 779
 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 W. S. Burney (M. D. or other) _____
Miller, M.D. Date signed 6-4-46

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

SUPPLEMENTARY

16081

