

No. 8-43  
5-17-39  
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26243

State File No. \_\_\_\_\_

**FILED** SEP 10 1946

Registration District No. 32

Primary Registration District No. 5713

Registrar's No. 48

1. PLACE OF DEATH:

(a) County BOLLINGER  
(b) City or town RURAL UNION TWP  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 13  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community LIFESTIME years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County BOLLINGER  
(c) City or town PATTON  
(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 JOHNATHAN PALISTINE 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 MARRIED

6. (b) Name of husband or wife MARCILLA JONES 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased JUNE 13 1874  
(Month) (Day) (Year)

8. AGE: Years 72 Months 1 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace BOLLINGER Co. MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMING

11. Industry or business \_\_\_\_\_

12. Name FRANKLIN JONES

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

14. Maiden name SUSAN BURHAM

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

16. (a) Informant MRS. J. P. JONES

(b) Address PATTON, MO.

17. (a) BURIAL (b) Date thereof 8-11-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PATTON CEM.

18. (a) Signature of funeral director BAKER FUNERAL HOME

(b) Address L. W. TESVILLE MO.

19. (a) Aug. 20 1946 (b) Willie H. Vandenberg  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 9<sup>th</sup>  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Shock Duration \_\_\_\_\_

Due to Automobile accident

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) Means of injury \_\_\_\_\_

23. Signature John J. Myers (M. D. or other) \_\_\_\_\_  
Address Patton, Mo. Date signed 8/27/46

**ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED**

PHYSICIAN

Underline the cause to which death should be charged statistically.

IVED

Health Officer No. 4

File Number 946-2585

Date Filed 9-9-46

SEP 25 1946

SEP 24 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. E. Graham

Licensed Embalmer No. 4010

P. O. Address Lutesville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept  
Registrar's No. 48

Registration District No. 32 Primary Registration District No. 5113

1. PLACE OF DEATH:  
(a) County Bollinger  
(b) City or town Rural  
(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 Johnathan P. Jones  
3. (b) If veteran \_\_\_\_\_ name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

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 \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death Shock

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced on  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased June 13 (Month) (Day) (Year)

Due to Automobile hitting him on highway 610  
Due to near Patton Mo  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy 1700/8

8. AGE: Years 72 Months 1 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo

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 \_\_\_\_\_

(a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (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)

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) Accident  
(b) Date of occurrence 8/9/46  
(c) Where did injury occur? Patton Bollinger Mo (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 John J. Hayes (M.D. or other) Patton  
Address Patton Mo Date signed 9/14/46

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

SUPPLEMENTARY

2508

20243