

FILED DEC 24 1946

Registration District No. 15

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3028

State File No. _____

Registrar's No. 256

41007

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
816 High St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 28 years (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper 49
(c) City or town Carthage 3
(If outside city or town limits, write "RURAL")
(d) Street No. 816 High St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____ 1)

3. (a) PRINT FULL NAME JOEL THOMAS JONES

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased September 9 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>2</u>	<u>28</u>	hr. _____ min. _____

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

10. Usual occupation retired laborer

11. Industry or business Independent Gravel Co.

12. Name Landy Jones

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

14. Maiden name Matilda Rousy

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

16. (e) Informant Mrs. C. W. Jones

(b) Address 902 Walnut St., Carthage, Mo

17. (a) burial (b) Date thereof Dec 10, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery
Knell Mortuary

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

19. (a) 12-10-46 (b) J. B. Clayton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 7
year 1946 hour _____ minute _____ P.M.

21. I hereby certify that I attended the deceased from DID NOT 19 _____ 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 Coronary Thrombosis (Myocardial) Acute
Due to Acute

Due to Distraction

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

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
Of operation _____
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 1
23. Signature J. B. Clayton (M. D. or other) 10
Address 2114 Joplin St. Joplin, Mo Date signed 12/10/46

139

46-12-1048

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..... *Frank W. Kneel Jr*

Licensed Embalmer No..... *1440*

P. O. Address..... *Carthage*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. Jan 256
Registrar's No. 256

Registration District No. 157

Primary Registration District No. 3028

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Joel J. Jones

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased Sept 9 (Month) 19 (Day) 19 (Year)

8. AGE: Years 76 Months _____ Days _____ 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 _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 _____

SUPPLEMENTARY

Myo-Carditis
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?

23. Signature _____ (Specify type of place) _____ (e) Means of injury _____
Address _____ Date signed _____

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