S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 5 1947

Registration District No. 139

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 920

Primary Registration District No. 4222

Registrar's No. 129

1. PLACE OF DEATH:

(a) County Holt

(b) City or town Bigelow Mo
(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 (Specify whether
In this community 86 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt 44 0

(c) City or town Bigelow Mo. 0
(If outside city or town limits, write "RURAL") 0

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Julia Jones

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife

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

7. Birth date of deceased Feby (Month) 17 (Day) 1860 (Year)

8. AGE: Years 86 Months 11 Days 16 If less than one day hr. min.

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

10. Usual occupation House Work

11. Industry or business

FATHER
12. Name Hosie Shaning
13. Birthplace (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Ann Mullins
15. Birthplace (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Guy Jones
(b) Address Bigelow MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Hope Mound City

18. (a) Signature of funeral director [illegible]
(b) Address Mound City MO

19. (a) Jan 15 (b) [illegible] (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 13
year 1947 hour 11 minute 20 P. M.

21. I hereby certify that I attended the deceased from Feb 1946 to Jan 13 1946
that I last saw her alive on Jan 13 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion — Duration 11 MO

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 94 P

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?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature F E Hogan (M. D. or other)
Address Mound City Date signed 1-15-46

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(Licensed Embalmer's Statement on Reverse Side)

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. 1824

P. O. Address Maysville City 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.