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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 8 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

8335

State File No.

Registration District No. 74 Primary Registration District No. 4135 Registrar's No. 9

1. PLACE OF DEATH:

(a) County Clinton

(b) City or town Gower (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 years, months or days)

In this community Entire life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clinton

(c) City or town Gower (If outside city or town limits, write "RURAL")

(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 SELENA 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 Married

6. (b) Name of husband or wife E. N. Jones

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Feb. (Month) 18 (Day) 1874 (Year)

8. AGE: Years 71 Months 1 Days 4 If less than one day hr. min.

9. Birthplace Clinton Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George W. Poage

FATHER 13. Birthplace Clinton Co (City, town, or county) Mo (State or foreign country)

MOTHER 14. Maiden name Rebecca J. Roy

MOTHER 15. Birthplace Clinton Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Miss Serena Poage

(b) Address Gower Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26-1947 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Zion

18. (a) Signature of funeral director H. A. Sullins

(b) Address Gower Mo

19. (a) Mar 25-1947 (Date received local registrar) (b) Bernice Chastain (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24 year 1947 hour 6 minute PM M.

21. I hereby certify that I attended the deceased from Mar 21, 1947, to Mar 24, 1947; that I last saw her alive on Mar 23, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocarditis	30 da
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Chronic Bronchitis	14 yr

Major findings: Of operations none

Of autopsy none

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

23. Signature J. W. Spalding (M. D. or other) MD

Address Platteburg Mo Date Mar 25-47

(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 W. A. Sullivan

Licensed Embalmer No. 1738

P. O. Address Gower 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.