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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13139

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 310

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 715 N. Main (Trotter Nursing Home) 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks (Specify whether
In this community 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Republic 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME May 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 M. Ellsworth Jones

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased Jan (Month) 2 (Day) 1868 (Year)

8. AGE: Years 79 Months 2 Days 29 If less than one day hr. min.

9. Birthplace Ithaca (City, town, or county) N.Y. (State or foreign country)

10. Usual occupation Housekeeping

11. Industry or business

FATHER
12. Name Geo Rhodes
13. Birthplace Dryden (City, town, or county) N.Y. (State or foreign country)

MOTHER
14. Maiden name Matilda P. ~~Rhodes~~
15. Birthplace Ithaca (City, town, or county) N.Y. (State or foreign country)

16. (a) Informant C. E. Jones
(b) Address 1619 E. Blaine Springfield

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 3 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Evergreen Cem.

18. (a) Signature of funeral director R. E. Thurman Med. Co.
(b) Address Republic Mo.

19. (a) 4-3-47 (Date received local registrar) (b) W. L. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 1-47
year hour 4 am minute M.

21. I hereby certify that I attended the deceased from 3-Calls 3/29/47, 19 to 3-31-41, 19
that I last saw her alive on 3/31-47, 19
and that death occurred on the date and hour stated above.

Immediate cause of death acute respiratory infection — Duration 1

Due to Bronchopneumonia & pleurisy

Due to Acute Diarrhoea

Other conditions Senile Dementia
(Include pregnancy within 3 months of death)

Major findings:
Of operations X
Of autopsy 107

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 Garrett Hogg M.D. (M.D. or other)
Address 1103 Roanoke Date signed 4/1/47

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(Licensed Embalmer's Statement on Reverse Side)

Diarrheal

SEP 18 1952

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 R. E. [illegible]

Licensed Embalmer No. 5003

P. O. Address Republic 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.