

No. 2
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5-17-35
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16386

Registration District No. 6 Primary Registration District No. 3001 Registrar's No. 12

1. PLACE OF DEATH:
(a) County Audrain
(b) City or town Vandalia
(c) Name of hospital or institution: C. State Street 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 20 yrs (years, months or days)

3. (a) PRINT FULL NAME ALBERT 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 Married
6. (b) Name of husband or wife Edna Earl Jones 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased October 30 1872 (Month) (Day) (Year)

8. AGE: 74 Years 6 Months 15 Days If less than one day hr. min.

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

10. Usual occupation Paper Hanger

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel Jones
13. Birthplace Ohio (City, town, or county) (State or foreign country)
14. Maiden name Abigail Miller (City, town, or county) (State or foreign country)
15. Birthplace Pennsylvania (City, town, or county) (State or foreign country)

16. (a) Informant Albert Jones Jr
(b) Address Mexico, Missouri

17. (a) Burial (b) Date thereof May 16, 1947 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Farber, Missouri

18. (a) Signature of funeral director W. S. Waters

(b) Address Vandalia, Missouri

19. (a) May 16 1947 (b) M. Allen Fuqua (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Audrain
(c) City or town Vandalia
(If outside city or town limits, write "RURAL")
(d) Street No. C. State Street 1 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1947 hour 3 minute P.M.
21. I hereby certify that I attended the deceased from September 23, 1946 to May 14, 1947 that I last saw him alive on May 14, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac de-compensation
Due to: Cardiac Hypertrophy
Due to: Arterial Sclerosis

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

Major findings: Of operations: Of autopsy: 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 _____

23. Signature R. E. Alford (M. D. or other) Address Vandalia, Mo. Date signed 5-16-47

RECEIVED
District Health Officer No. 10
District File Number 47-879
Date filed MAY 20 1947

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 Tom B. Waters
Licensed Embalmer No. 4169
P. O. Address Urbana, Ill.

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.