

V. S. No. 2
00M-2-43
Rev. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21482**

FILED JUL 9 1947

Registration District No. **70**

Primary Registration District No. **5630**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Rural, Lebanon, Route #3
(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 4 1/2 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede 53
(c) City or town Rural (1)
(If outside city or town limits, write "RURAL")
(d) Street No. Route 3 Lebanon (2)
(If rural, give location) (0)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ira S. Jones

3. (b) If veteran, name was Spanish-American 3. (c) Social Security No. 487-07-2811

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married
(b) Name of husband or wife Mattie Jones 6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased Jan. 16 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 5 4 _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Jones 9
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Jeanette Flat
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mattie Jones

(b) Address Lebanon Rt. 3

17. (a) Burial (b) Date thereof 6/23/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lebanon Mo

18. (a) Signature of funeral director Palmer

(b) Address Lebanon Mo

19. (a) 6-28-1947 (b) Ors Frankhuger
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20 year 1947 hour 2 minute 10 A. M.

21. I hereby certify that I attended the deceased from June 19, 1947, to time of death, 1947; that I last saw him alive on June 19, 1947, and that death occurred on the date and hour stated above.
Immediate cause of death Coronary thrombosis Duration _____

Due to Angina pectoris

Due to _____

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

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? _____

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

23. Signature P. S. Anderson (M. D. or other) DO
Address Lebanon, Mo. Date signed 6/21/47

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

Received 7/8/47
Laclede County Health Unit
File No. 6-47-111
Date Filed 7/8/47

JUL 10 1947
JUL 23 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 S. P. Palmer

Licensed Embalmer No. 2208

P. O. Address Lebanon 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.