

No. 2  
-12-45  
-17-39  
K47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24784  
Registrar's No. 216

FILED AUG 12 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 5725

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

1. PLACE OF DEATH:

(a) County Macon Co., Mo.  
(b) City or town rural Hudson  
(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)

3. (a) PRINT FULL NAME Evans A. Jones

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M.O. 5. Color or race W. 6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: July 1st 1897  
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace New Cambria Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Morgan D. Jones 4

13. Birthplace Wales 4 (City, town, or county) (State or foreign country)

14. Maiden name Jane Roberts 4

15. Birthplace Wales 4 (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Earl Brindley  
(b) Address Paris, Mo. R.1.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-15-47 (Month) (Day) (Year)

(c) Place: burial or cremation New Cambria Mo.

18. (a) Signature of funeral director Stephen A. Holling  
(b) Address Macon Mo.  
19. (a) 7-21-47 (Date received local registrar) (b) Pat M. Neely (Registrar's signature) 1957

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon 61  
(c) City or town Paris 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. Macon Mo. R.1.D. 0  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12  
year 47 hour 11 minute 08 P. M.

21. I hereby certify that I attended the deceased from 5-25  
1946 to June 12 1947  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis 30/46  
Due to Generalized arteriosclerosis several  
Due to \_\_\_\_\_ years

Other conditions Chronic Psych  
(Include pregnancy, state months of death)  
& Chr Prostate

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy ✓ 6/30

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 J. E. Hill (M. D. or other) M.D.  
Address Macon Mo. Date signed 7-3-47

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 10  
District File Number 7-47-915  
Date Filed JUL 30 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 C. H. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, 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.