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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 20 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27369

Registration District No. 128 — Primary Registration District No. 2000 — Registrar's No. 717

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: St Johns Hospital (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 7 months 16 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield (If outside city or town limits, write "RURAL")
(d) Street No. 1449 N. Lyon Ave., (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Kenneth 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 Single
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased December 29, 1946 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	7	16	hr. min.

9. Birthplace Springfield (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Infant
11. Industry or business At Home
FATHER
12. Name Homer Jones
13. Birthplace Springfield (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name Naioma Johnson
15. Birthplace Springfield (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Homer Jones
(b) Address Springfield Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn
18. (a) Signature of funeral director J.W. Klingner & Co.
(b) Address Springfield Mo.
19. (a) 8-16-47 (Date received local registrar) (b) W E Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15 year 1947 hour 11 minute 00 A. M.
21. I hereby certify that I attended the deceased from Feb 24, 1947, to Aug 15, 1947 that I last saw him alive on Aug 15, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Anhydremia, Dehydration, Acidosis	
Due to Pyelonephritis	
Due to	
Other conditions Hydrocephalus, arrested (Include pregnancy within 3 months of death) Cord Bladder	
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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature Eva Evans Jr. (M. D. or other)
Address 510 Woodruff Bldg. Date signed Aug 16, 47

(Licensed Embalmer's Statement on Reverse Side)

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 Max Rhodes

Licensed Embalmer No. 4071

P. O. Address Springfield

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.