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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. De Tan
State File No. 28104
Registrar's No.

Registration District No. 156 Primary Registration District No. 2001

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Joplin
(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 4 weeks (Specify whether years, months or days)

3. (a) PRINT FULL NAME Jane Shirley Jones
3. (b) If veteran, name war _____
3. (c) Social Security No. 514-24-47

4. Sex Female 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 June 26 1927
(Month) (Day) (Year)

8. AGE: Years 20 Months 1 Days 9
If less than one day hr. _____ min. _____

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

10. Usual occupation Bookkeeper

11. Industry or business box office

12. Name Geo. Jones

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

14. Maiden name Marie Squieres

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

16. (a) Informant Geo. Jones

(b) Address Baxter Springs

17. (a) Removed (b) Date thereof 8-7-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stard, Stank

18. (a) Signature of funeral director Wlene Funeral Home

(b) Address Baxter Springs

19. (a) 8-12-47 (b) Delores Sampson, D.P.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Cherokee
(c) City or town Baxter Springs
(If outside city or town limits, write "RURAL")
(d) Street No. 335 Willow ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 4
53 year 1947 hour 4:50 minute 50 P.M.
21. I hereby certify that I attended the deceased from 7-6-47 to 8-4-47
that I last saw her alive on 8-4-47
and that death occurred on the date and hour stated above.

Immediate cause of death Acute ascending Myelitis Duration 40 days
Due to Fracture of third, fourth, fifth and sixth dorsal vertebrae with forward displacement of the fourth dorsal vertebrae 40 days
Due to Hemorrhage and compression of the cord.
Other conditions 15-1708
(Include pregnancy within 3 months of death)

Major findings: Laminectomy of the 3rd, 4th, 5th, & 6th dorsal vertebrae
Of operations Auto wreck.
Of autopsy S.H.P. - Car she was riding

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Auto wreck
(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) (c) Means of injury _____
23. Signature Boyle (M.D. or other) M.D.
Address 527 Frisco Bldg., Joplin Date signed 8-9-47

47-8-692

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.....

Wene Funeral Home

Registered Apprentice No.....

working under my personal supervision.

Signed.....

J. James Wene

Licensed Embalmer No.....

2880

P. O. Address.....

Bayter Bldg H

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.