

No. 2
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5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 5 1947

Registration District No. 375

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30184

Primary Registration District No. 6288

Registrar's No. 40

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Grove Springs Rural Union
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
At his home 5 miles north of Grove Springs
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None / (Specify whether
In this community 82 yrs.
years, months or days)

3. (a) PRINT FULL NAME WILLIAM LABORN JONES

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Nancy A. Jones 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. 7 15 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 24 hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Toliver Jones

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

14. Maiden name Phoebe Smith

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

16. (a) Informant Toliver Jones

(b) Address Grovesprings Mo.

17. (a) Burial (b) Date thereof 8 10 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cuba Cem.

18. (a) Signature of funeral director Gene E. Holden

(b) Address Hartsville, Mo.

19. (a) Aug. 29, 1947 (b) E. Garner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wright
(c) City or town Grove Springs Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 5 miles north of Grove Springs
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 9
year 1947 hour 2:00 minute 30 P.M.

21. I hereby certify that I attended the deceased from 8
4 1947 to 8-9 1947
that I last saw him alive on 8-9 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 5 days

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operation J. H. Hughes

Of autopsy 108

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? 17

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

23. Signature _____ (M. D. or other)

Address Grove Springs Mo. Date signed 8-10-47

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 947-947

Date Filed SEP 3 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 Gene E Holdren

Licensed Embalmer No. 3865

P. O. Address Hartsville, Md

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.