

S. No. 2
 OM-2-43
 v. 5-17-39
 X35627

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED SEP 16 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30205

State File No. _____
 Registrar's No. **242**

Registration District No. **1** Primary Registration District No. **3000**

1. PLACE OF DEATH:
 (a) County **Adair**
 (b) City or town **Kirkville**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Grim - Smith
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **4 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Knox**
 (c) City or town **Novelty**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____
(Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Sarah Margaret Jones**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **John C. Jones** 6. (c) Age of husband or wife if alive **87** years
 7. Birth date of deceased **Feb - 12 - 1864**
(Month) (Day) (Year)

8. AGE: Years **83** Months **6** Days **7**
If less than one day hr. min.

9. Birthplace **Knox County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Homekeeper**

11. Industry or business _____

MOTHER FATHER
 12. Name **Thomas Rimer**
 13. Birthplace **Towbridge England**
(City, town, or county) (State or foreign country)
 14. Maiden name **Mary Ann Deary**
 15. Birthplace **uk Scotland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edna Jones**
 (b) Address **Novelty Mo.**

17. (a) **Burial** (b) Date thereof **Sept-9-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Novelty Mo.**

18. (a) Signature of funeral director **Keith Hudson**
 (b) Address **Edina Mo.**

19. (a) **Sept 8-47** (b) **Kate Lambert**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **7** year **1947** hour **9** minute **40 A.M.**

21. I hereby certify that I attended the deceased from **Sept. 4** 19**47** to **Sept 7** 19**47**
 that I last saw ~~her~~ **her** alive on **Sept 7** 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis, degenerative, chronic** **1 year**
 Duration

Due to _____

Due to _____

Other conditions **Hypertension** **years**
(Include pregnancy within 3 months of death)
Peritonitis, cause unknown **3 days**

Major findings:
 Of operations _____
 Of autopsy **12.1**

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) (e) Means of injury

23. Signature **J. P. ...** (M. D. or other **MD.**)
 Address **Kirkville, Mo.** Date signed **9/14/47**

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

STATEMENT BY LICENSED EMBALMER

RECEIVED
District Health Officer No. 10
District No. 9-47-1235
Date Filed SEP 15 1947

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 Arthur Hudson

Licensed Embalmer No. 2415

P. O. Address Edina, Minn.

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.