

S. No. 2
1-1/47
7-5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30686**

FILED OCT 8 1947
Registration District No. **23**

Primary Registration District No. **4113**

Registrar's No. **28**

1. PLACE OF DEATH:

(a) County **CHARITON**

(b) City or town **BRUNSWICK**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **CHARITON**

(c) City or town **BRUNSWICK**
(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 **EDWARD JONES**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **MALE** 5. Color or race **COL.**

6. (a) Single, widowed, married, divorced **WIDOWER**

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **JAN. 19-1869**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **SEPT** day **7th**
year **1947** hour **3** minute **0** M.

21. I hereby certify that I attended the deceased from **Sept. 5th**
1947 to **Sept. 7th**, **1947**
that I last saw him alive on **Sept. 7th**, **1947**
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	78	7	18	hr. _____ min.

Immediate cause of death **Acute Respiratory Failure**

Due to **Cerebral Hemorrhage** **3 days**

Other conditions (include pregnancy within 3 months of death) _____

9. Birthplace **BRUNSWICK MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED FARMER**

11. Industry or business _____

12. Name **SAMUEL JONES**

13. Birthplace **BRUNSWICK MISSOURI**
(City, town, or county) (State or foreign country)

14. Maiden name **SUSAN M. BRUDER**

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

16. (a) Informant **COMPTON JONES**
(b) Address **ST. LOUIS MO.**

17. (a) **BURIAL** (b) Date thereof **9-10-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BRUNSWICK MO**

18. (a) Signature of funeral director **[Signature]**
(b) Address **BRUNSWICK MO.**

19. (a) **9-10-47** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

Major findings: _____

Of operations _____

Of autopsy _____

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 **[Signature]** (M. Registrar) **D.O.**
Address **Brunswick, Mo.** Date signed **9/7/47**

MOTHER FATHER

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

RECEIVED

District Health Officer No. 8

District File Number _____

Date Filed 10-7-47

7930

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 L. M. McIsaac

Licensed Embalmer No. 823

P. O. Address Brunswick 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.