S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 3 1947

Registration District No. 27

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5949

State File No. 32087

Registrar's No. 39

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Rural - Cuivre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No (Specify whether
In this community - 60 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pike 82
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 7 mi. N.W. of Bowling Green 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James B. Jones
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Ora McClure Jones
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept. (Month) 17 (Day) - 1865 - (Year)

8. AGE: Years 81 Months 11 Days 23 If less than one day hr. min.

9. Birthplace Frankford (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation Retired
11. Industry or business Farming
FATHER
12. Name John B. Jones
13. Birthplace Kentucky / (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Lois E. Geery
15. Birthplace Pike Co (City, town, or county) Mo 0 (State or foreign country)
16. (a) Informant Mrs Hayden Lawrence
(b) Address Bowling Green
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Frankford Mo
18. (a) Signature of funeral director W. B. Elmore
(b) Address Bowling Green
19. (a) 9-23-47 (Date received local registrar) (b) Bill Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 10 year 1947 hour 7 minute 20 A.M.
21. I hereby certify that I attended the deceased from 1933 to 9/10 1947
and that I last saw him alive on 9/10 1947
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Cerebral Apoplexy	3 yrs
Due to Arterio Sclerosis	10 yrs
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 83 A	
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 J. M. Mathews M.D. (M. D. or other)
Address Bowling Green Mo. Date signed 9-10-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-47-1234
Date OCT - 1 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 W. B. Elsore

Licensed Embalmer No. 3466

P. O. Address Bowling Green

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.