

FILED NOV 10 1947

Registration District No. 27

Primary Registration District No. 2006

Registrar's No. 26749

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Institution Home, Mary Catherine Elliott, 1521 W. Clay
(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 Sullivan
(c) City or town Osgood Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME VIRGIL E JONES

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

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 19 1867
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>3</u>	<u>3</u>	hr. min.

9. Birthplace Wentzville, Sullivan Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired mcht

11. Industry or business Drug store

12. Name Ferry E Jones

13. Birthplace U.S.A.
(City, town, or county) (State or foreign country)

14. Maiden name Ediga Sandefur

15. Birthplace U.S.A.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Eastwood

(b) Address Osgood Mo

17. (a) Burial (b) Date thereof Oct 25-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Grav Cem.

18. (a) Signature of funeral director Dr. Bayne T. Son

(b) Address Galt Mo

19. (a) Oct-25-47 (b) Francis B. Neill
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22
year 1947 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 1947 to Oct 22 1947
that I last saw him alive on Oct 20 1947
and that death occurred on the date and hour stated above.

Immediate Cause of death Cerebral Thrombosis Sudden Duration _____

Due to _____
Due to _____

Other conditions _____ (Include pregnancy, within 3 months of death)

Major findings:
Of operations _____
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?

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature McCauley (M. D. or other) _____
Address Chillicothe Mo Date signed 10-22-47

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

MOTHER FATHER

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *P. K. Payne Jr*

Licensed Embalmer No. *3400*

P. O. Address..... *Galt*

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.