

No. 2
12-45
17-39
X47070

FILED DEC 12 1947
Registration District No. 2477

Primary Registration District No. 5786

Registrar's No. 106

1. PLACE OF DEATH:

(a) County Mississippi

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

(c) Name of hospital or institution:
Route 2, Box 394
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 5 years

In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mina Jones

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

4. Sex Female 5. Color or race Negro

6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased October 5, 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

58	1	24	hr. min.
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9. Birthplace Houston, Mississippi
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name Unknown 9

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

14. Maiden name Hulda Walker

15. Birthplace Houston, Miss. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lela Horton

(b) Address R.2, Box 394, Charleston, Mo.

17. (a) Burial (b) Date thereof Dec. 3, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director F. D. Sparks

(b) Address Charleston, Missouri

19. (a) 12-3-47 (Date received local register) (b) Mrs. J. Lee Bondurant (Registrar's signature) 101

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi 67

(c) City or town Charleston (Rural) 0
(If outside city or town limits, write "RURAL")

(d) Street No. Route 2, Box 394 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 29
year 1947 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct 26, 1947, to Nov. 29, 1947.
that I last saw her alive on Nov 29, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Peptic Ulcer, Secondary Anemia

Due to Chronic Gastritis

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: None
Of operations _____

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(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 Harriet S. Cleverley (M.D. or other) _____

Address I209-W Date signed 12-2-47

Duration

33-DAYS
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

Washington Cairo, Ill

RECEIVED

District Health Office No. 2

District File Number 1247-155

Date Filed 12-8-42

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 Frank Sparks

Licensed Embalmer No. 3455

P. O. Address Cape Girardeau 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.