

FILED JAN 6 1948

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

40889

Do not use this space.

1. PLACE OF DEATH

(a) County Bonne Registration District No. 40
(b) Township Rocky Fork Primary Registration District No. 4057 Registered No. 6 10
(c) City Hallsville (d) Street No. _____ St. J
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 25-yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.)

2. PRINT FULL NAME John Milton Jones

(a) Residence, No. Hallsville St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nodie Helen Jones

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 27 - 1871

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
76 7 25

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Stockman
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bath Co. Ky.13. NAME Josiah Jones14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.15. MAIDEN NAME Lidia Perrot16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.17. INFORMANT Irvin Jones
(ADDRESS) Columbia, Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Red Top Cem. DATE Dec. 24, 194719. FUNERAL DIRECTOR (NAME) Parker Funeral Ser.
(ADDRESS) Columbia, Mo.20. FILED Dec 24, 1947 Mrs. G. L. Shock
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 22, 194722. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1947, to Dec 20, 1947, 1947.I last saw him alive on Dec 20, 1947. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Cerebral Haemorrhage Date of onset 12-18-47Other contributory causes of importance: Arteriosclerosis 57.0Name of operation none Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 1947

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) W. K. ... M. D.(Address) Columbia, Mo.

FILED
1/5/47
RECEIVED
OFFICE No. 9

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 Thas L. Waring
Licensed Embalmer No. 4132
P. O. Address Columbia, 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, above space should be left blank.