S. No. 2
—1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED APR 26 1948

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 12273

Registration District No. 132 Primary Registration District No. 3021 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Grundy
(b) City or town Rural-home Northern (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Allen Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution since March 4 (Specify whether
In this community 80 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Grundy
(c) City or town Trenton (If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME Glancy Johnson Jones
3. (b) If veteran, name war None
3. (c) Social Security No. —
4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife deceased
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Dec (Month) 9 (Day) 1860 (Year)

8. AGE: Years 87 Months 3 Days 11 If less than one day hr. min.

9. Birthplace Kentucky (City, town, or county) (State or foreign country)
10. Usual occupation farming
11. Industry or business agriculture
FATHER
12. Name William Jones
13. Birthplace USA (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Eliz Ann Estes
15. Birthplace USA (City, town, or county) (State or foreign country)
16. (a) Informant Edna Foot
(b) Address Trenton, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 22-1948 (Month) (Day) (Year)
(c) Place: burial or cremation Bratton Cemetery
18. (a) Signature of funeral director Oliver Gipson
(b) Address Trenton Mo
19. (a) Mar. 22-1948 (Date received local registrar) (b) Irene Fair (Registrar's signature) 115

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 20 year 1948 hour minute M.
21. I hereby certify that I attended the deceased from Mar 10 1948 to Mar 20 1948; that I last saw him alive on Mar 20 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia — Duration 1 hr
Due to Fracture of hip
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations 1860
Of autopsy 1918

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN
Underline the cause of 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 [signature] (M. D. ~~or other~~)
Address Trenton Mo Date signed 3/20/48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Gordon Blackmae Registered Apprentice No. 78 working under my personal supervision.

Signed Chas D Upson

Licensed Embalmer No. 2109

P. O. Address Trenton, 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.

No. 2B
3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 12273

Registration District No. 132 Primary Registration District No. ✓ Registrar's No.

**1. PLACE OF DEATH:**

(a) County Grundy

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

(c) Name of hospital or institution: Cullum Hospital
(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)

In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County

(c) City or town
(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 Glancy J. Jones

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec 9 (Month) (Day) (Year)

8. AGE: Years 87 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Ky (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March 20 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| 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

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S. No. 2B
1-3-45
P1X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 132 Primary Registration District No. 3021 Registrar's No.

**1. PLACE OF DEATH:**

(a) County: Grundy
(b) City or town: Rural
(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 (Specify whether years, months or days)
In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County
(c) City or town (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: Glenn J. Jones
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive: Years
7. Birth date of deceased: Dec 9 (Month) (Day) (Year)
8. AGE: Years 87 Months 3 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Ky (State or foreign country)
10. Usual occupation
11. Industry or business
12. FATHER Name
13. FATHER Birthplace (City, town, or county) (State or foreign country)
14. MOTHER Maiden name
15. MOTHER Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March Day 20 year 1948 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

| Immediate cause of death | 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): Accident
(b) Date of occurrence: 3/4/48
(c) Where did injury occur? Her home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home or farm (Specify type of place)
While at work? No (e) Means of injury: Fall
23. Signature: [illegible] (M. D. or other)
Address Date signed 4/30/48

SUPPLEMENTARY

(52) 12278