

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25168**
Registrar's No. **43**

Registration District No. **340**

Primary Registration District No. **3075**

1. PLACE OF DEATH:
(a) County **Stoddard**
(b) City or town **Dexter**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **10 hours** (Specify whether)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Stoddard** / 103
(c) City or town **Dexter** 2
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? **No.** (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME **Leo Jones**
(b) If veteran, name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **8th**
year **1948** hour **11 A.M.** minute _____ M. _____

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **single**
(b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **July 8 1948**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **7-8-48**, 1948, to **7-8-48**, 1948, that I last saw him alive on **7-8-48** and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months _____ Days _____ If less than one day **10 hr.** min. _____

Immediate cause of death **Cerebral Beriberi, 7 1/2 months** Duration _____
Due to **Cause of Cerebral Beriberi**
Due to _____

9. Birthplace **Dexter** (City, town, or county) **Mo.** (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations **159**
Of autopsy **no.**

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER
12. Name **Gilbert Jones**
13. Birthplace **Bloomfield Mo.** (City, town, or county) (State or foreign country)
14. Maiden name **Helena Beyerbach**
15. Birthplace **Bloomfield Mo.** (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant **Gilbert Jones**
(b) Address **Malden, Mo.**
17. (a) **Burial** (b) Date thereof **July 8 48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Walker Cemetery**

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature **J. S. Davis** (M. D. or other) _____
Address **Dexter Mo.** Date signed **7-8-48**

18. (a) Signature of funeral director **Watkins Fun. Ser. Inc**
(b) Address **Dexter Mo.**
19. (a) **7-16-48** (b) **Velma V. Jenkins**
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A REVERSE

RECEIVED
District Health Office No. 2
District File Number 288 909
Date Filed 7-19-48

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 Not embalmed, Registered Apprentice No. _____ working under my personal supervision.

Signed Lynnan Steele
Licensed Embalmer No. 2476
P. O. Address Nexter, 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.