

2-45
17-39
X47070

FILED AUG 27 1948

Registration District No. **360**

Primary Registration District No. **3076**

Registrar's No. **136**

1. PLACE OF DEATH:

(a) County **Vernon**
 (b) City or town **Nevada**
 (c) Name of hospital or institution: **Hesper Ambulance on Way Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2 years**
 In this community **2 years**
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo.** (b) County **Vernon**
 (c) City or town **rural**
 (d) Street No. **N. West - Nevada**
 (e) Citizen of foreign country? **no.**
 If yes, name country

3. (a) PRINT FULL NAME **MILD S. JONES**

3. (b) If veteran name war **W.W. # 2**
 3. (c) Social Security No. **516-01-3413**

4. Sex **male** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Vergie Mason Jones**
 6. (c) Age of husband or wife if alive **18** years
 7. Birth date of deceased **Aug. 2 1893**
 (Month) (Day) (Year)

8. AGE: Years **55** Months **0** Days **14**
 If less than one day hr. min.

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

10. Usual occupation **Farming**

11. Industry or business

12. Name **Tifford J. Jones**
 13. Birthplace **Caldwell Co. Mo.**
 14. Maiden name **Laura L. Thomas**
 15. Birthplace **Ray Co. Mo.**

16. (a) Informant **Mrs. Vergie M. Jones**
 (b) Address **Richards, Mo.**
 17. (a) **Removal** (b) Date thereof **Aug. 19, 1948**
 (c) Place: burial or cremation **Richmond, Mo.**

18. (a) Signature of funeral director **E. H. Hays**
 (b) Address **Nevada, Mo.**
 19. (a) **8-23-48** (b) **Walter H. Yancy**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **18**
 year **1948** hour **2** minute **30** A.M.
 21. I hereby certify that I attended the deceased from **MAY 22**
 19**48** to **Aug 18**, 19**48**
 that I last saw him alive on **Aug 18**, 19**48**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Respiratory Center Paralysis**
 Due to **Acute Cerebral edema**
Pulmonary edema
Arteriosclerotic Ht. Disease
Cerebral Arteriosclerosis
 Other conditions **depression**
 (Include pregnancy within 3 months of death)

Duration
1 hr.

10 hrs
3 hrs

PHYSICIAN

Major findings:
 Of operations **none**
 Of autopsy **none**

Underline the cause to which death should be charged statistically.
935

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?
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature **W. M. Miller, M.D.**
 Address **Nevada, Mo.** Date signed **8/22/48**

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

RECEIVED

District Health Officer No. 7,

District File Number 7-48-980

Date Filed 8-26-48

AUG 31 1948

SEP 3 1948

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 Mark Eickinger

Licensed Embalmer No. 2655-

P. O. Address Nevada, 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.