DEPARTMENT OF COMMERCE
BUREAU OF THE C...

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

NOV 20 1940

State File No. 35692

Registration District No. 467 Primary Registration District No. 4280 Registrar's No. 67

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

1. PLACE OF DEATH:

(a) County Laurence

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

(c) Name of hospital or institution: 707 Adams Aurora mo (If not in hospital or institution, write street number or location) 2

(d) Length of stay: In hospital or institution at Home (Specify whether

In this community 20 yrs (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laurence

(c) City or town Aurora mo (If outside city or town limits write "RURAL")

(d) Street No. 707 Adams ave (If rural, give location)

(e) If foreign born, how long in U. S. A.? ... years.

8. (a) PRINT FULL NAME Sadie M. Jones

8. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July 9 (Month) (Day) 1858 (Year)

8. AGE:	Years	Months	Days	If less than one day
	82	5	13	... hr. ... min.

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

10. Usual occupation House wife

11. Industry or business —

MOTHER FATHER

12. Name Washington Mitchell

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

MOTHER

14. Maiden name Unknown

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

16. (a) Informant Will E. Jones

(b) Address 707 Adams ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 40 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill, Kansas

18. (a) Signature of funeral director [illegible]

(b) Address 139 W Church Aurora Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 21 day Monday year 1940 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from Oct 11, 1940 to Oct 21, 1940 that I last saw h... alive on Oct 11, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Senility	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations

Of autopsy

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? No

While at work? No (Specify type of place) (e) Means of injury

23. Signature Will E. Jones (M. D. another)

Address 139 W Pleasant Aurora Mo Date signed Oct 22/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 1640—2812
Date Filed NOV 6 1940

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.

No. 2B
2-21-40
I X22659

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

ROWENA MOORE

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38-692

Registration District No. 467 Primary Registration District No. 4286 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Lawrence
(b) City or town Aurora
(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
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. 4 (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Sadie M. Jones
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 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 (Month) (Day) (Year)

8. AGE: Years 82 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) 11-2-40 (Date received local registrar) (b) R. D. Cowan, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21
year 1940 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.

	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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. Will Smith (M. D. or other)
Address Aurora Mo Date signed