

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
529 South Orchard st
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 years
years, months or days

3. (a) PRINT FULL NAME HESTER MAY JONES

3. (b) If veteran, name war _____ 3. (c) Social Security No. 490-05-8108

4. Sex F 5. Color or race W 6. (a) Single; widowed, married, divorced married
6. (b) Name of husband or wife Adrian 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased Mar 7 1889
(Month) (Day) (Year)

8. AGE: Years 53 Months 9 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace COOPER Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation News Paper (rep)

11. Industry or business _____

MOTHER FATHER
12. Name George Harvey
13. Birthplace Cooper Co mo
(City, town, or county) (State or foreign country)
14. Maiden name Carla WATSON
15. Birthplace Cooper Co mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs C Stone

(b) Address Clinton mo

17. (a) Burial (b) Date thereof 12-11-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Englewood

18. (a) Signature of funeral director Consensus & Beck

(b) Address Clinton mo

19. (a) Dec 11, 1942 Georgia Kitchener
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Henry
(c) City or town Clinton mo
(If outside city or town limits, write "RURAL")
(d) Street No. 529 S Orchard
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10
year 1942 hour 2:45 minute AM

21. I hereby certify that I attended the deceased from June
_____ 1942 to Dec 10 _____ 1942

that I last saw her alive on Dec 10 _____ 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Nephritis
due to Corcoran's of
Liver + Pancreas
Died at home

Duration

Due to _____

Other conditions Starvation (unable
(Include pregnancy within 3 months of death)
to take food)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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 Guido V. ... (D. or other) _____

Address Clinton, Mo. Date signed Dec 11 1942

No. 2
9-41
5-17-39
I X29484

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

42
2
1

RECEIVED

District Health Officer No. 7, *APR 1914*

District File Number *2-42-1431*

Date Filed *1-14-43*

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. *1891*

P. O. Address *Clinton 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.