

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14597

State File No.

Registration District No. 291 Primary Registration District No. 5993 Registrar's No. 32

1. PLACE OF DEATH: Putnam
(a) County Putnam
(b) City or town Lucerne Medicine
(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. Lifetime (Specify whether years, months or days)

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

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive 29 1877
7. Birth date of deceased Jan (Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 23 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name George Jones 9

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

14. Maiden name Wintersville Sullivan Co Mo

15. Birthplace Wintersville Sullivan Co Mo (City, town, or county) (State or foreign country)

16. (a). Informant J.W. Moore

(b) Address Newtown

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28-47 (Month) (Day) (Year)

(c) Place: burial or cremation Newtown

18. (a) Signature of funeral director Edith A. Jones

(b) Address Newtown

19. (a) 4-5-47 (Date received local registrar) (b) Marcell Durbin (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 23 rd
year 1947 hour 4 minute P.
21. I hereby certify that I attended the deceased from Mar. 18 th 1947 to Mar. 23 rd 1947
that I last saw him alive on Mar. 23 rd 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure
Due to Lobar pneumonia.
Due to

Other conditions 108
(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? 2

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

23. Signature G.H. Dale (M. D. or other)

Address Newtown Mo Date signed 3/26/47

266 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File Number 447-694
Date Filed APR 15 1947

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, fact should be so stated above.