

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

17602

1. PLACE OF DEATH 85
 County Buchanan Registration District No. 1001
 Township _____ Primary Registration District No. _____
 City St. Joseph (No. _____) St. _____ Ward _____
 2. FULL NAME William Henry Jones
 (a) Residence. No. 506 S 16th Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred, yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Caucasian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED Widowed Alice O. Jones
 (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 12 1854
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 8 6
 8. OCCUPATION OF DECEASED Teacher
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____
 9. BIRTHPLACE (CITY OR TOWN) Plattsburg Mo
 (STATE OR COUNTRY) _____
 10. NAME OF FATHER Zogan Jones
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not Known
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Not Known
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not Known
 (STATE OR COUNTRY) _____

MEDICAL CERTIFICATE OF DEATH 6 PM

16. DATE OF DEATH (MONTH, DAY AND YEAR) 17 June 1927
 17. I HEREBY CERTIFY That I attended deceased from 8 AM 15 June 1927 to 2 PM 17 June 1927
 that I last saw him alive on 17 June 1927, and that death occurred, on the date stated above, at 6:00 PM.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic valvular Heart Disease (Mitral Insufficiency)
 (duration) yrs. mos. ds. 2 9
 CONTRIBUTORY Angina Pectoris
 (SECONDARY) (duration) yrs. mos. ds. 2
 18. WHERE WAS DISEASE CONTRACTED? _____
 IF NOT AT PLACE OF BIRTH, _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical test
 (Signed) Ed. Stearns M. D.
20/6, 1927 (Address) 1408 Meade
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Mora Cem DATE OF BURIAL 6-21 1927
 20. UNDERTAKER B. F. Graves ADDRESS 1309 N 4th

14. INFORMANT B. F. Graves
 (Address) 1309 N 4th St
 15. FILED 21 1927 John J. [Signature] REGISTRAR

