

FILED MAY 24 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

18058

State File No.

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 398

1. PLACE OF DEATH:

(a) County Greene
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Burge Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 4 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Sharon Elizabeth Jones

3. (b) If veteran, name war none 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive XX years
 7. Birth date of deceased April - 16 - 1944
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
no no 21 X hr. X min.

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

10. Usual occupation Infant11. Industry or business X

12. Name Peggy Lou Jones
 13. Birthplace Webster County, Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Peggy Lou Jones
 15. Birthplace Laclede Co. Co. Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Peggy Lou Jones
 (b) Address Marshfield, Missouri
 17. (a) Burial (b) Date thereof 5-7-44
 (Burial, cremation or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Marshfield, Mo.

18. (a) Signature of funeral director W. J. Jones
 (b) Address Marshfield, Mo.
 19. (a) 5-8-44 (b) W. J. Jones
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster
 (c) City or town Rural, Marshfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. Ozark township
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7
 year 1944 hour 9:40 minute A.M.

21. I hereby certify that I attended the deceased from 3-5-44 19. to 3-7- 19 44
 that I last saw her alive on 3-7- 19 44
 and that death occurred on the date and hour stated above.

Immediate cause of death Anhydremic Intoxication
 Due to Starvation

Other conditions Mongolism
 (Include pregnancy within 3 months of death)
 Major findings: Gonorrhea vaginalis
 Of operations
 Of autopsy 2512

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 W. J. Jones (M. D. or other)
 Address Springfield, Mo. Date signed 5-8-44

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.

X