

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14670
5

BIRTH NO. _____ REG. DIST. NO. 368 PRIMARY REG. DIST. NO. 247 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <i>Washington Rural</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN <i>Johnsontown</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Rural</i>	
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) <i>Near Antoinette Mill Mo.</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Near Antoinette Mill Mo.</i>			
3. NAME OF DECEASED (Type or Print) a. (First) <i>Marguerette Nettie</i> b. (Middle) _____ c. (Last) <i>Jones</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>May 2 1949</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>March 17 1880</i>
9. AGE (In years) (If under 1 year last birthday) <i>69</i>		10. MONTHS <i>1</i>	11. DAYS <i>15</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <i>Harding Ill.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Marion F. Noel</i>		13b. MOTHER'S MAIDEN NAME <i>Unknown</i>	
14. NAME OF HUSBAND OR WIFE <i>Earl R. Jones</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <i>Earl R. Jones</i>		ADDRESS <i>Antoinette Mill Mo.</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Apoplexy</i> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <i>Cerebral Hemorrhage</i> DUE TO (c) <i>hypertension & weak heart</i> II. OTHER SIGNIFICANT CONDITIONS <i>Pract</i> Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>8:28 P. m.</i> , from the causes and on the date stated above.			
23a. SIGNATURE <i>Luther Frank Petric</i> (Degree or title) _____		23b. ADDRESS <i>Paris Mo</i>	
23c. DATE SIGNED <i>5/4/49</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>6-5-49</i>	
24c. NAME OF CEMETERY OR CREMATORY <i>Metcalfe Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>Washington Co. Mo</i>	
DATE REC'D BY LOCAL REG. <i>MAY 6 1949</i>		REGISTRAR'S SIGNATURE <i>[Signature]</i>	
FUNDING DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS <i>Mr. Luther Frank Petric Mo.</i>	

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

RECEIVED

District Health Officer No. 4

District File Number 549-626

Date Filed 5-10-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Murphy Sparks

Signed _____
Student Embalmer

Licensed Embalmer No. 4236

P. O. Address State Street, 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.