

FILED JUN 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14711**

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 2000 Registrar's No. 159

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE Missouri COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville	
d. FULL NAME OF HOSPITAL OR INSTITUTION 715 W. Dodson St.		d. STREET ADDRESS (If rural, give location) 715 W. Dodson	

3. NAME OF DECEASED (Type or Print) a. (First) Henry	b. (Middle)	c. (Last) Jones	4. DATE OF DEATH (Month) (Day) (Year) 5/30/1949
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5. SEX Male	6. COLOR OR RACE NEGRO Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 12, 1863	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (State or foreign country) Clarinda, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Mary Frances Wilson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mary Lampkins, Kirksville, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 15 years 44 2X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio-vascular-renal disease DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS 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"/>
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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 August 1, 1945 to May 30, 1949, that I last saw the deceased alive on May 30, 1949, and that death occurred at 11:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE Howard E. Gross, D.O.	(Degree or title)	23b. ADDRESS Kirksville, Mo.	23c. DATE SIGNED May 31, 1949
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/1/49	24c. NAME OF CEMETERY OR CREMATORY Llewellyn	24d. LOCATION (City, town, or county) (State) Kirksville, Missouri
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DATE REC'D BY LOCAL REG. 6-2-49	REGISTRAR'S SIGNATURE Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE Paul H. [unclear]	ADDRESS Kirksville, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No.

District File Number 6-49

Date Filed JUN 8 - 1949

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.

Student
Student Embalmer

Signed Roy H. Mercer

Licensed Embalmer No. 4432

P. O. Address Kirkville, 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.