

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23099

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BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 640

1. PLACE OF DEATH a. COUNTY - GREENE			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY Greene		
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) Willard, Mo		d. STREET ADDRESS (If rural, give location) Murray Twp
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			d. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) a. (First) Lucy b. (Middle) A. c. (Last) JONES			4. DATE OF DEATH (Month) (Day) (Year) July 18 1949		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH November-19-1873	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months 7 Days 29
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home Keeper	11. BIRTHPLACE (State or foreign country) Tenn		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John Sweaggy		13b. MOTHER'S MAIDEN NAME Isabel Conroy	14. NAME OF HUSBAND OR WIFE Hughes W. Jones		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Hughes W. Jones, Willard, Mo. ADDRESS			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Neoplasm ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary Tuberculosis for adv. (First diagnosed 1 mo. ago) DUE TO (c) Hyperextension				INTERVAL BETWEEN ONSET AND DEATH 7 or 8 weeks Several years 20 1/2 years 1 year
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	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 7-4 , 1949, to 7-18 , 1949, that I last saw the deceased alive on 7-17 , 1949, and that death occurred at 5:45 a.m. , from the causes and on the date stated above.					
23a. SIGNATURE V. S. E. [Signature] (Degree or Title)			23b. ADDRESS Medical Coll Bldg, Springfield		23c. DATE SIGNED 7/19/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 20 1949	24c. NAME OF CEMETERY OR CREMATORY Rose Hill	24d. LOCATION (City, town, or county) (State) Near Willard MO		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 7-20-49 W. J. Lowrey	25. FUNERAL DIRECTOR'S SIGNATURE Gene A. Brown	ADDRESS Walnut Grove MO			

(Licensed Embalmer's Statement on Reverse Side)

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

JUL 5 7 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 James P. Phyllis
Licensed Embalmer No. 4641

P. O. Address Walnut Grove, Wisc.

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.