

FILED NOV 17 1949

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36491**

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

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 4058 Registrar's No. 415

1. PLACE OF DEATH a. COUNTY BUTLER			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY BUTLER		
b. CITY (If outside corporate limits, write RURAL and give township) HARVIELL		c. LENGTH OF STAY (in this place) 1	c. CITY (If outside corporate limits, write RURAL and give township) HARVIELL		
d. FULL NAME OF HOSPITAL OR INSTITUTION HARVIELL, MO.			d. STREET ADDRESS (If rural, give location) NONE		
3. NAME OF DECEASED (Type or Print) EMMA		a. (First)	b. (Middle) (NONE)	c. (Last) JONES	4. DATE OF DEATH (Month) (Day) (Year) OCT 29 1949
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH JAN 27, 1868	9. AGE (in years last birthday) 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME THORNTON SMITH		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE THOMAS B. 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 THOMAS B. JONES		ADDRESS HARVIELL MISSOURI		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) cerebral hemorrhage	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) hypertension		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. —		INTERVAL BETWEEN ONSET AND DEATH 391X	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —		19a. DATE OF OPERATION no.		19b. MAJOR FINDINGS OF OPERATION no.	
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 Oct 20, 1949 , to Oct 29, 1949 , that I last saw the deceased alive on _____, 19____, and that death occurred at 7:00 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE Steele White MD		(Degree or title)		23b. ADDRESS Waverly Rd	
23c. DATE SIGNED 10/29/49		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE OCT 30/49	
24c. NAME OF CEMETERY OR CREMATORY CORNING		24d. LOCATION (City, town, or county) (State) CORNING Ark		DATE REC'D BY LOCAL REG. Nov 8, 1949	
REGISTRAR'S SIGNATURE Wm. H. Johnson		428		FUNERAL DIRECTOR'S SIGNATURE Richard O. Burnett	
ADDRESS Corning Ark					

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BUTLER COUNTY HEALTH CENTER
POPLAR BLUFF, MISSOURI

DEC 5 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 Richard O. Etnier

Licensed Embalmer No. 782

P. O. Address Leaning, Ark.

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.