

FILED MAR 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Shaffer 4710
State File No.
Registrar's No. 11

BIRTH NO. _____ REG. DIST. NO. 142 PRIMARY REG. DIST. NO. 5556

1. PLACE OF DEATH a. COUNTY Howell		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Howell	
b. CITY (If outside corporate limits, write RURAL and give township) Mountain View		c. CITY (If outside corporate limits, write RURAL and give township) Mountain View	
c. LENGTH OF STAY (In this place) 25 years		d. STREET ADDRESS (If rural, give location) Galdsberry Trpk.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Galdsberry Trpk.			
3. NAME OF DECEASED a. (First) William		b. (Middle) Dallas	
c. (Last) Jones		4. DATE OF DEATH (Month) (Day) (Year) Feb 24-50	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb 12-1867
9. AGE (In years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	11. BIRTHPLACE (State or foreign country) Elwood, Indiana
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Not known		13b. MOTHER'S MAIDEN NAME Not known	
14. NAME OF HUSBAND OR WIFE Nancy A. 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.	
17. INFORMANT'S SIGNATURE OR NAME Dorothy Jones, Mtn View, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crown Throat Lead ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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"/>			
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 2/24, 1950 , to 2/24, 1950 , that I last saw the deceased alive on 2/23, 1950 , and that death occurred at 4:50 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE James R. Shaffer M.D.		23b. ADDRESS Mtn View Mo.	
23c. DATE SIGNED 2/27/50			
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 2-27-50	24c. NAME OF CEMETERY OR CREMATORY GREEN LAWN	24d. LOCATION (City, town, or county) (State) Mt. View Mo
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 3-1-1950	REGISTRAR'S SIGNATURE Laura Mitchell	FUNERAL DIRECTOR'S SIGNATURE J. R. Duncan	ADDRESS Mt. View Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 3/2/50
District Health Officer No. 8;

District File Numbers 350-147

Date Filed 3/3/50

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 _____

working under my personal supervision.

Student
Student Embalmer

Signed Joe R. Duncan
Student Embalmer No.
Licensed Embalmer No. 43257
P. O. Address W. View

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.