

STANDARD CERTIFICATE OF DEATH

Dr. Fitch
State File No. 12319
Registrar's No. 410

FILED MAY 15 1951

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5463

390

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. Missouri Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Rural Jackson Twp.		c. CITY (If outside corporate limits, write RURAL and give township) Rural Jackson Twpsh.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Route # 2 Strafford, Mo.		d. STREET ADDRESS (If rural, give location) Route # 2 Strafford, Mo.	

3. NAME OF DECEASED (Type or Print) a. (First) Emma b. (Middle) Katherine c. (Last) Jones			4. DATE OF DEATH (Month) May , (Day) 7 , (Year) 1951		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 4 1872	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME James Monroe Jones		13b. MOTHER'S MAIDEN NAME Emma Sophia (Unknown)		14. NAME OF HUSBAND OR WIFE X	
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. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Howard Jones Rt # 2 Strafford, Mo.	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arterio Sclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Smoking			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4200	
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)		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 _____, 1947, to 6-7, 1951, that I last saw the deceased alive on 5-7-51, 19____, and that death occurred at 9:15 p.m. from the causes and on the date stated above.

23a. SIGNATURE M.D.		23b. ADDRESS Springfield Mo		23c. DATE SIGNED 5-9-51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5/9/51		24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24d. LOCATION (City, town, or county) (State) Des Moines Iowa	
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DATE REC'D BY LOCAL REG. 5/9/51		REGISTRAR'S SIGNATURE W. E. Landry M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H.H. Lohmeyer Springfield, Mo.	
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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.

Signed.....
Student Embalmer

Signed *Sam Johnson* Student Embalmer No.

Licensed Embalmer No. *4734*

P. O. Address *Spokane, Idaho*

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.