

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27797

FILED SEP 12 1951

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 287

1. PLACE OF DEATH a. CITY Pettis 0804		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pettis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia 0804	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 1301 Marshall 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Knox Rest Home			

3. NAME OF DECEASED (Type or Print) a. (First) NELLE b. (Middle) FRANKLIN c. (Last) JONES			4. DATE OF DEATH (Month) (Day) (Year) Sept. 5, 1951			
5. SEX Fe	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 10, 1871	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Madison, Missouri 0		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Joseph Davis		13b. MOTHER'S MAIDEN NAME Mary Dunaway		14. NAME OF HUSBAND OR WIFE John Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) ***		16. SOCIAL SECURITY NO. *****		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Otto Wright, Blackwell, Okla.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis & Myocardial Degeneration		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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. Paralysis Agatans				10 yrs	

19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION *****		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		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 May 26, 1951, to Sept 5, 1951, that I last saw the deceased alive on Aug 24, 1951, and that death occurred at 2 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Hanna A. Walker, D.O.		23b. ADDRESS 400 W 4th St Sedalia, Missouri		23c. DATE SIGNED 6 Sept 51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Sept 7, 1951		24c. NAME OF CEMETERY OR CREMATORY Crown Hill	
		24d. LOCATION (City, town, or county) (State) Sedalia, Mo			

DATE REC'D BY LOCAL REG. 9/7-1951		REGISTRAR'S SIGNATURE C. Campbell M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sedalia, Mo	
		REGISTRAR'S SIGNATURE C. Campbell M.D.		FUNERAL DIRECTOR'S SIGNATURE W. Beckert	

(Licensed Embalmer's Statement on Reverse Side)

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

GILLESPIE FUNERAL HOME

RECEIVED 9-11-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 9-11-51 _____

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 _____
O. W. Eckhart

Licensed Embalmer No. 3470 _____

P. O. Address _____
Sedalia, 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.