

FILED NOV 5 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32495

BIRTH NO. _____		REG. DIST. NO. <u>11</u>		PRIMARY REG. DIST. NO. <u>4024</u>		Registrar's No. <u>80</u>	
1. PLACE OF DEATH a. COUNTY <u>Barry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Barry</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Cassville</u>		c. LENGTH OF STAY (in this place) <u>1 hr.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Wheaton</u>		<u>6050</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Dr. G.W. Salyer's office</u>				d. STREET ADDRESS (If rural, give location) <u>none</u>			
3. NAME OF DECEASED (Type or Print) s. (First) <u>Inez</u> b. (Middle) <u>Ruth</u> c. (Last) <u>Jones</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 17, 1951</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 20, 1951</u>		9. AGE (In years last birthday) <u>1</u> <u>27</u>	If UNDER 1 YEAR Days <u>27</u> Hours <u></u> Min. <u></u>	If UNDER 1 HR. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Wheaton, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Lonnie Lee Jones</u>			13b. MOTHER'S MAIDEN NAME <u>Mona Lavon Coffman</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mona Jones, Wheaton, Mo.</u> ADDRESS <u></u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>493X</u>				INTERVAL BETWEEN ONSET AND 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) _____ m. _____		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 <u>Oct. 17 @ 11:00</u> 19 <u>51</u> , to <u>Oct. 17 @ 11:20</u> 19 <u>51</u> , that I last saw the deceased alive on <u>Oct. 17</u> , 19 <u>51</u> , and that death occurred at <u>11:20</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Herbert T. Salyer M.D.</u> (Degree or title)				23b. ADDRESS <u>Cassville Mo.</u>		23c. DATE SIGNED <u>Oct. 17, 1951</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/18/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mc. Pleasant Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Barry County, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>10-22-1951</u>		REGISTRAR'S SIGNATURE <u>Grace Williams</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Koon</u>		ADDRESS <u>Cassville, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

050

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED **OCT 29 1951**

Dist. File 11371919
Date Filed 11-2-51

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 _____

working under my personal supervision.

Not Embalmed

Student Embalmer No.

Signed

W. C. Koon

Signed.....
Student Embalmer

Licensed Embalmer No. 4359

P. O. Address Cassville, 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.