

STANDARD CERTIFICATE OF DEATH

FILED FEB 4 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2080

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Burge Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>1679 E. Belmont</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>FRED</b>	b. (Middle)	c. (Last) <b>JONES</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 31 1952</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>4-15-1906</b>	9. AGE (In years last birthday) <b>45</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Business</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wild Cherry Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		

13a. FATHER'S NAME <b>C. Wesley Jones</b>	13b. MOTHER'S MAIDEN NAME <b>Nola Wilson</b>	14. NAME OF HUSBAND OR WIFE <b>Brennie Lou Jones</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(3)</b>	16. SOCIAL SECURITY (If yes, give war or dates of service) <b>431-01-1007</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Brennie L. Jones</b>	ADDRESS <b>Spfld. Mo.</b>
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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		INTERVAL BETWEEN ONSET AND DEATH  <b>28 hrs.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Anoxia, hemorrhage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Bilateral stone in chest</b> DUE TO (c) <b>Multiple fractures of all ribs</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Left hemopneumothorax Right hemothorax, intrac-</b>		E 8164 26	

19a. DATE OF OPERATION <b>30 Jan 52</b>	19b. MAJOR FINDINGS OF OPERATION <b>Aspiration of air by left thoracostomy</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Springfield, intersection Springfield, Greene, Missouri</b>	21c. (CITY, TOWN, OR TOWNSHIP) <b>133</b> ; (COUNTY) _____ (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Jan 30 1952 8A.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Collision of automobile</b>

22. I hereby certify that I attended the deceased from **30 Jan, 1952**, to **31 Jan, 1952**, that I last saw the deceased alive on **31 Jan, 1952**, and that death occurred at **12:55p.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Robert W. Mader, M.D.</b>	23b. ADDRESS <b>Medical Arts Bldg., Springfield, Missouri</b>	23c. DATE SIGNED <b>17 Feb 1952</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>2-2-1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Greenlaw</b>	24d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>2-1-52</b>	REGISTRAR'S SIGNATURE <b>James H. Amor, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Klingner &amp; Co.</b>	ADDRESS <b>Spfld. Mo.</b>
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WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

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Dr. Mader, M.D.

4-10-03

**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 William B. Cantrell

Licensed Embalmer No. 7820

P. O. Address Springfield, 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.