

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

SEP 15 1952

BIRTH NO. _____		REG. DIST. NO. <u>116</u>	PRIMARY REG. DIST. NO. <u>3020</u>	Registrar's No. <u>137</u>
1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>		
b. CITY (If outside corporate limits, write RURAL and give township) <u>Washington</u>	c. LENGTH OF STAY (In this place) <u>5 da.</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Washington</u> <u>0362</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>545 East 5th St. 0</u>		
3. NAME OF DECEASED (Type or Print) <u>HOWARD</u>	a. (First) <u>HOWARD</u>	b. (Middle) <u>MILTON</u>	c. (Last) <u>JONES</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>9 4 1952</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-11-1864</u>	9. AGE (In years last birthday) <u>88</u> Months <u>4</u> Days <u>23</u> IF UNDER 18 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Relief Worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>	11. BIRTHPLACE (State or foreign country) <u>Belle, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Charles C. Jones</u>	13b. MOTHER'S MAIDEN NAME <u>Ruby M. Perkins</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, state year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. John Rabe Hink, 545 East 5th St. Washington</u>		
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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Neuroleptic meningitis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chr. gastritis</u> DUE TO (c) <u>gastro ulcers</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>arteria sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>20 yrs</u> <u>90 yrs</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>5400</u>			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) (Min.)	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>Aug 30</u> , 19 <u>52</u> to <u>Sept 4</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>52</u> and that death occurred at <u>9:12</u> m., from the causes and on the date stated above.				
23a. SIGNATURE <u>J. M. ...</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Washington Mo</u>	23c. DATE SIGNED <u>9-6-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9-7-1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Belle Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Radair, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Sept. 6, 1952</u>	REGISTRAR'S SIGNATURE <u>F.S. Sudman</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter F.H. By ... Washington, Mo.</u>		

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

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

W. W. Wilbur

Licensed Embalmer No. 4511

P. O. Address Washington, 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.