

STANDARD CERTIFICATE OF DEATH

State File No. 37599

FILE DEC 2 1952

BIRTH NO. REG. DIST. NO. 15 PRIMARY REG. DIST. NO. 3004 Registrar's No. 74

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

1. PLACE OF DEATH a. COUNTY Barton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Dade	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lamar Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lockwood rt 1	
c. LENGTH OF STAY (In this place) 6 da		0290	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lamar Memorial Hospital		d. STREET ADDRESS (If rural, give location) Ceder twp	

3. NAME OF DECEASED (Type or Print)	a. (First) Lillie	b. (Middle) Ann	c. (Last) Jones	4. DATE OF DEATH (Month) (Day) (Year) NOV 24 1952
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept 8 1876	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Days 2	IF UNDER 24 HRS. Hours 16
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	10b. KIND OF BUSINESS OR INDUSTRY house wife	11. BIRTHPLACE (State or foreign country) Johnson co mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James A Barton	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Perry Jones
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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. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Perry Jones Lockwood Mo rt 1
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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 14 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Gen. Arteriosclerosis		years
	DUE TO (c) Auricular Fibrillation		3 days
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 3 32x	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Nov. 13, 1952, to 11-24, 1952, that I last saw the deceased alive on Nov. 23, 1952, and that death occurred at 2:30 PM, m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H.M. Arnold M.D.	23b. ADDRESS Lamar Mo.	23c. DATE SIGNED 11-24-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov 26 1952	24c. NAME OF CEMETERY OR CREMATORY New Bethel	24d) LOCATION (City, town, or county) (State) Dade Co Mo
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DATE REC'D BY LOCAL REG. NOV 24 1952	REGISTRAR'S SIGNATURE Marie Konarski 14-a	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.R. Allison Greenfield 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.

Student Embalmer No.....

Signed.....

W. R. Allison

Signed.....

Student Embalmer

Licensed Embalmer No. *4404*

P. O. Address.....

Greenfield

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.