

FILED JAN 8 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42798

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3041 Registrar's No. 128

1. PLACE OF DEATH a. COUNTY <b>Macon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>MACON</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Macon</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>New Cambria</b>	
c. LENGTH OF STAY (in this place) <b>3 days</b>		d. STREET ADDRESS (If rural, give location) <b>XXXXXXX</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Samaritan hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Robert</b>	b. (Middle) <b>J.</b>	c. (Last) <b>Jones</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 17, 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>Feb. 9, 1878</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months <b>10</b>	IF UNDER 1 YEAR Days <b>8</b>	IF UNDER 1 YEAR Hours <b></b>	IF UNDER 1 YEAR Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm owner-Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Chariton County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>David R. Jones</b>	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE <b>Elizabeth Parry Jones</b>
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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) <b>No.</b>	16. SOCIAL SECURITY NO. <b>XXXX</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Lloyd Jones, New Cambria, Mo.</b>	ADDRESS <b>New Cambria, 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>2 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Embolism</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Generalized Arteriosclerosis (Abdominal)</b> DUE TO (c) _____		
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 <b>1991</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 **Oct 16, 1952** to **Dec 17, 1952**, that I last saw the deceased alive on **Dec 17, 1952**, and that death occurred at **10:30 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Arthur M. Massoy, M.D.</b>	(Degree or title) <b>2</b>	23b. ADDRESS <b>Macon, Mo.</b>	23c. DATE SIGNED <b>12/18/52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Dec. 19, 1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>New Cambria</b>	24d. LOCATION (City, town, or county) (State) <b>New Cambria, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>12/18/52</b>	REGISTRAR'S SIGNATURE <b>Arthur M. Massoy</b>	185	25. FUNERAL DIRECTOR'S SIGNATURE <b>H. G. Hill</b>	ADDRESS <b>New Cambria, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 12.52.30  
MACON COUNTY HEALTH DEPARTMENT  
County File No. 1.53.1981  
Date Filed 1.53.3

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 \_\_\_\_\_

Licensed Embalmer No. 4019

P. O. Address New Cambria, 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.