

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23726**

FILED JUL 1 - 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **372** PRIMARY REG. DIST. NO. **4343** Registrar's No. **11**

1. PLACE OF DEATH a. COUNTY <b>WEBSTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>MO.</b> b. COUNTY <b>WEBSTER</b>	
b. CITY OR TOWN <b>Seymour Mo.</b>		c. CITY OR TOWN <b>SEYMOUR MO.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <b>0</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>MARY</b>	b. (Middle) <b>MELVINA</b>	c. (Last) <b>JONES</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>6-21-53</b>
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5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>5-18-1878</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Greene Co.</b>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <b>Benjamin Alsop</b>	13b. MOTHER'S MAIDEN NAME <b>JANE STOUT</b>	14. NAME OF HUSBAND OR WIFE <b>S. D. JONES</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Gilbert Jones, Seymour</b>	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cremia depending on myeloma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Sepsis due to fecal fistula</b>		?
	DUE TO (c) <b>Chronic Regional Enteritis</b>		?
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	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) <b>Seymour Webster Mo.</b>
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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?
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22. I hereby certify that I attended the deceased from **May-15, 1952**, to **June-21, 1953**, that I last saw the deceased alive on **June-26, 1953**, and that death occurred at **8:30 AM**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. R. Gill</b>	(Degree or title) <b>N. O.</b>	23b. ADDRESS <b>Seymour</b>	23c. DATE SIGNED <b>6/22/53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>6-26-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>GREENE LAWN</b>	24d. LOCATION (City, town, or county) (State) <b>GREENE CO.</b>
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DATE REC'D BY LOCAL REG. <b>6-28-53</b>	REGISTRAR'S SIGNATURE <b>Gilbert Jones</b>	FUNERAL DIRECTOR'S SIGNATURE <b>Robert Bergman</b>	ADDRESS <b>Seymour Mo</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

*Max J Miller*

Licensed Embalmer No. *4720*

P. O. Address *Manfield 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.