

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31505**

FILED OCT 13 1953

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>930</u>			
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 OR TOWN <b>Springfield</b>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <b>Willard</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>				• STREET ADDRESS (If rural, give location) <b>Willard RFD#2</b> <span style="float: right;"><u>0390</u> <u>1</u></span>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>HOWARD</b>			b. (Middle)		c. (Last) <b>JONES</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>October 3 1953</b>		
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>20 July 1900</b>		9. AGE (In years last birthday) <b>53</b> # UNDER 1 YEAR: Months _____ Days _____ # UNDER 24 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13a. FATHER'S NAME <b>Harry Jones</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Manning</b>			14. NAME OF HUSBAND OR WIFE <b>Rena Jones</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Rena Jones</b>		ADDRESS <b>Willard, Mo. RFD#2</b>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypertensive Cardio-Vascular Renal Disease</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Raynaud's Disease</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Encephalopathy due to Hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>20 yrs</b> <b>3 weeks</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4530</b>					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)		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>10-16</u> , 19 <u>52</u> , to <u>10-3</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>10-3</u> , 19 <u>53</u> , and that death occurred at <u>6:15P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <b>W. J. Darr, M.D.</b> (Degree or title)				23b. ADDRESS <b>609 Cherry Springfield Mo.</b>			23c. DATE SIGNED <b>10/2/53</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Oct. 6, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cemetery Greene Co. Missouri</b>		24d. LOCATION (City, town, of county) (State)			
DATE REC'D BY LOCAL REG. <b>10-5-53</b>		REGISTRAR'S SIGNATURE <b>Edith Williamson</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J.W. KLINGNER &amp; CO. Springfield, Mo.</b>				

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

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Ogle Howe Jr.*.....

Licensed Embalmer No. *4176*.....

P. O. Address *Springfield*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.