No. 500
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11819

BIRTH NO. FILED APR 26 1954 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 387

1. PLACE OF DEATH
a. COUNTY: GREENE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, S. Campbell Twp.
c. LENGTH OF STAY (In this place): 2mos. 9days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Medical Center for Federal Prisoners

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY: Cook
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chicago 8120 S
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) Franklin c. (Last) Jones
4. DATE OF DEATH: (Month) April (Day) 15, (Year) 1954
5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 3
8. DATE OF BIRTH: April 20, 1905
9. AGE (In years last birthday): 48 | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Varied
11. BIRTHPLACE (State or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY?: USA
13a. FATHER'S NAME: Paul Colman Jones
13b. MOTHER'S MAIDEN NAME: Margaret (?) Jones
14. NAME OF HUSBAND OR WIFE: Divorced
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME, ADDRESS: FILE: M.C.F.P., Springfield, Missouri

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inanition — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Fistula leading to Jejunum, post operative — 4 mos. 23 das
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* 9137 46

19a. DATE OF OPERATION: 11-23-53 11-30-53
19b. MAJOR FINDINGS OF OPERATION: Laceration of recto-sigmoid. Foreign body (60 watt light bulb) with associated abscess ~~inferior to transverse meso-colon.~~
20. AUTOPSY? YES [X] NO [ ]

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) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that* ~~I~~ The Medical Staff *attended the deceased from* Feb. 6, 19 54, *to* April 15, 19 54, *that I last saw the deceased alive on* April 15, 19 54, *and that death occurred at* 9:45 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: E. C. Rinck (Degree or title) E. C. RINCK, M.D., Clinical Director
23b. ADDRESS: Medical Center for Fed. Prisoners, Springfield, Missouri
23c. DATE SIGNED: 4-19-54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 4/20/1954
24c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery
24d. LOCATION (City, town, or county) (State): Springfield, Mo.,

DATE REC'D BY LOCAL REG.: 4-20-54
REGISTRAR'S SIGNATURE: Ruth Williamson
25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: Clyde Goodwin Springfield, Mo
(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
SPRINGFIELD, MISSOURI
625 West Walnut

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 _____ Signed _____
Student Embalmer

Licensed Embalmer No. 4594

P. O. Address Springfield, Misso

Note:— The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.