

FILED AUG 9 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25905

BIRTH NO. _____		REG. DIST. NO. <u>322</u>		PRIMARY REG. DIST. NO. <u>3071</u>		Registrar's No. <u>24</u>	
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u>		c. LENGTH OF STAY (In this place) <u>50yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u>		09710	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>none</u>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>David</u>		b. (Middle) <u>John</u>		c. (Last) <u>Jones</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 3rd - '54</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr. 22nd, 1880</u>		9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>11</u>	IF UNDER 24 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Wales, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13a. FATHER'S NAME <u>Joe Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Phillips</u>		14. NAME OF HUSBAND OR WIFE <u>[REDACTED]</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>709-10-3749</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. J. E. Mooney Slater, Mo.</u>			
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) <u>Chronic Myocarditis & Cardiac Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Asthma</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diverticulosis of sigmoid</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Years _____</u> <u>Minutes _____</u> <u>Years _____</u> <u>10 years _____</u> <u>years _____</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4221</u>		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) (Min.)		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>4-2</u> , 19 <u>52</u> , to <u>8-3</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>8-3</u> , 19 <u>54</u> , and that death occurred at <u>8 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>P. A. McBurney M.D.</u>				23b. ADDRESS <u>Slater, Mo.</u>		23c. DATE SIGNED <u>8/5/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>8/5/'54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Slater - Mo.</u>		
DATE REC'D BY LOCAL REG. <u>8-6-54</u>		REGISTRAR'S SIGNATURE <u>Mrs. E. Metz 2920</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hill Brothers Slater</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

mo

NOV 7 1954

SEP 17 1954

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. 3090

P. O. Address State, 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.