

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26837

FILED AUG 16 1954

State File No.

No. 300
10.48

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 743A

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY OR TOWN Springfield	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 3 days		e. STREET ADDRESS (If rural, give location) 1024 East Walnut Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Handley Memorial Hospital			

3. NAME OF DECEASED (Type or Print) GRETA	a. (First)	b. (Middle) LOUISE	c. (Last) JONES	4. DATE OF DEATH (Month) (Day) (Year) Aug. 1, 1954
--	------------	---------------------------	------------------------	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Dec. 26, 1903	9. AGE (in years last birthday) 50	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
----------------------	-------------------------------	--	---------------------------------------	---	------------------------	-----------------------	------------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Joplin, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	---	--	--

13a. FATHER'S NAME Grant Davis	13b. MOTHER'S MAIDEN NAME Elizabeth Selmore	14. NAME OF HUSBAND OR WIFE Hobart B. Jones
---------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Arneata Cantrell, Seymour, Mo.	ADDRESS
---	--	---	---------

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure + Pneumonia		3 da - 3 wks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Rheumatic Heart Disease - 20 yrs 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	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) m.	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 July 29 19 54 to July 31, 19 54 that I last saw the deceased alive on July 30, 19 54 and that death occurred at 2:20 p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) David H. Hall M. D.	23b. ADDRESS Springfield, Missouri	23c. DATE SIGNED 8/2/1954
---	---	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8/3/1954	24c. NAME OF CEMETERY OR CREMATORY Seymour Cemetery	24d. LOCATION (City, town, or county) (State) Seymour, Missouri
--	---------------------------	--	--

DATE REC'D BY LOCAL REG. 8-9-54	REGISTRAR'S SIGNATURE Etha Williams	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS AYRE-GOODWIN FUNERAL SERVICE Springfield, Mo.
--	--	---

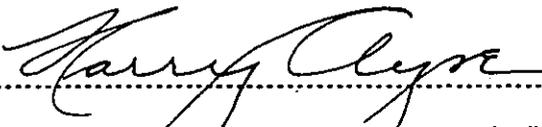
(Licensed Embalmer's Statement On Death Certificate)

623 West Walnut
SPRINGFIELD, MISSOURI
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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No...4..5..9

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.**