

FILED SEP 14 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28200
61

BIRTH NO.		REG. DIST. NO. 385		PRIMARY REG. DIST. NO. 3039		Registrar's No. 61	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY LINN		c. LENGTH OF STAY (in this place) 2 DAYS		a. STATE MO		b. COUNTY LINN	
b. CITY (If outside corporate limits, write RURAL and give township) MARCELINE		d. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS HOSP		c. CITY (If outside corporate limits, write RURAL and give township) MARCELINE		d. STREET ADDRESS (If rural, give location) WEST SANTA FE	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX	
a. (First) SAMUEL		b. (Middle) W.	c. (Last) JONES		8 - 23 - 54		M
6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED		8. DATE OF BIRTH 19 MAR. 1868		9. AGE (In years last birthday) 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (City and State or Foreign Country) EAST TENNESSEE		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME EMUEL JONES		13b. MOTHER'S MAIDEN NAME MIRIAM O'DELL		14. NAME OF HUSBAND OR WIFE NONE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME MRS JOE E. JONES FT. MADISON, MO			
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) Heart failure					
		ANTECEDENT CAUSES DUE TO (b) Coronary insufficiency					
		DUE TO (c) Generalized arteriosclerosis					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. - Fractured 9 to 11 th ribs on left.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201 F				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 AUG 21, 1954, to AUG 22, 1954, that I last saw the deceased alive on AUG 22, 1954, and that death occurred at 11 PM. m., from the causes and on the date stated above.							
23a. SIGNATURE George J. Gray, M.D.				23b. ADDRESS Marceline, Mo.		23c. DATE SIGNED 8-24-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 8-26-54		24c. NAME OF CEMETERY OR CREMATORY ROSELINDA		24d. LOCATION (City, town, or county) (State) MARCELINE, MO	
DATE REC'D BY LOCAL REG. 8-24-54		REGISTRAR'S SIGNATURE Mary J. Reigway		25. FUNERAL DIRECTOR'S SIGNATURE James M. ... Marceline, Mo			

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 George D. Russell

Licensed Embalmer No. 4425

P. O. Address Mandeville, 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.