

FILED JAN 4 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41803

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>242</u>		PRIMARY REG. DIST. NO. <u>4361</u>		Registrar No. <u>21</u>			
1. PLACE OF DEATH a. COUNTY <u>Scott - New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If different, residence before admission) a. STATE <u>MO</u>				b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Canallo</u>		c. LENGTH OF STAY (in this place) <u>10 years</u>		c. CITY OR TOWN <u>Canallo</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION				STREET ADDRESS (If rural, give location) <u>Edo 0720</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>HENRY MARION</u>			b. (Middle) _____		c. (Last) <u>JONES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12-19-1954</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>8/26/1876</u>		9. AGE (In years last birthday) <u>78</u> IF UNDER YEAR Months Days <u>3 6</u> IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Oakman Alabama U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13a. FATHER'S NAME <u>Samuel Jones</u>			13b. MOTHER'S MAIDEN NAME <u>Beckie Turner</u>			14. NAME OF HUSBAND OR WIFE <u>Hina Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Earl A Jones - Doctor Mich</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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <u>4201</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) (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 <u>12-18, 1954</u> , to <u>12-19, 1954</u> ; that I last saw the deceased alive on <u>12-19, 1954</u> , and that death occurred at <u>10:55 pm.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>L. G. Jones M.D.</u>				23b. ADDRESS <u>Morehouse Mo.</u>			23c. DATE SIGNED <u>12-21-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>12/23/1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Little Spring</u>		24d. LOCATION (City, town, or county) (State) <u>Cantraville MO</u>			
DATE REC'D BY LOCAL REG. <u>12-30-54</u>		REGISTRAR'S SIGNATURE <u>Thomas M. Sheeter</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Edmond P. Gombrow Ark</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.4820  
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JAN 4 1955

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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 *Homer L. Ponder*

Licensed Embalmer No. *336*

P. O. Address *Lilbourn*

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.