

FILED FEB 23 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3815.

State File No.

BIRTH NO. 6430-55 REG. DIST. NO. 10 PRIMARY REG. DIST. NO. 3002 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY Audrain		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Audrain	
b. CITY (If outside corporate limits, write RURAL and give township) Mexico	c. LENGTH OF STAY (in this place) 9 hrs	c. CITY OR TOWN Mexico	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Audrain County Hospital		STREET ADDRESS (If rural, give location) 610 West Maple Street	

3. NAME OF DECEASED (Type or Print)	a. (First) Michelle	b. (Middle) Marie	c. (Last) Jones	4. DATE OF DEATH (Month) (Day) (Year) Feb. 12 1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) child	8. DATE OF BIRTH Feb. 12, 1955	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 9
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and State or Foreign Country) Mexico, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Carroll Jones	13b. MOTHER'S MAIDEN NAME Donna Holland	14. NAME OF HUSBAND OR WIFE Child
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Carroll Jones	ADDRESS Mexico, Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH 2 hours 9 hours
	I. DISEASE OR CONDITION - DIRECTLY LEADING TO DEATH* (a) Respiratory failure	DUE TO (b) Prematurity	
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 1735	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Feb 12, 1955 to Feb 12, 1955, that I last saw the deceased alive on Feb 12, 1955, and that death occurred at 1:45 m., from the causes and on the date stated above.

23a. SIGNATURE Ernest Lawrence M. D.	(Degree or title)	23b. ADDRESS Mexico, Mo.	23c. DATE SIGNED 2-14-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-13-1955	24c. NAME OF CEMETERY OR CREMATORY Eastlawn Memorial Park	24d. LOCATION (City, town, or county) (State) Mexico, Missouri
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DATE REC'D BY LOCAL REG. Feb 13 1955	REGISTRAR'S SIGNATURE Blanche Neely	25. FUNERAL DIRECTOR'S SIGNATURE Arnold Funeral Home	ADDRESS Mexico, Mo.
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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: *Richard Y M Glenn*

Licensed Embalmer No. *482*

P. O. Address *Medicine*

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.