

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29343

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 93 PRIMARY REG. DIST. NO. 4153 Registrar's No. 55-75

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Lockwood Mo</u>		c. CITY OR TOWN <u>Lockwood Mo</u>	
c. LENGTH OF STAY (in this place) <u> yrs</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>East 9th St</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Margaret</u> b. (Middle) <u>Jane</u> c. (Last) <u>Jones</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 13, 1955</u>		
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5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>		8. DATE OF BIRTH <u>July 30, 1872</u>		9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>house keeper</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Dade Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
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13a. FATHER'S NAME <u>Joe Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Annie Kearn</u>		14. NAME OF HUSBAND OR WIFE	
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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) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Lewis Gillman</u> ADDRESS <u>Lockwood Mo</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Neuronopathy</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>331x.</u>		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)			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 9-8- 1955, to 9-13- 1955, that I last saw the deceased alive on 9-13- 1955, and that death occurred at 4:45P m., from the causes and on the date stated above.

23a. SIGNATURE <u>Max Heilmann M.D.</u> (Degree or title)		23b. ADDRESS <u>Lockwood, Mo</u>		23c. DATE SIGNED <u>9-14-55</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-15-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Pipinger</u>		24d. LOCATION (City, town, or county) (State) <u>Dade Co Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>9-15-55</u>		REGISTRAR'S SIGNATURE <u>J. C. Canada</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.R. Allison</u> ADDRESS <u>Greenfield Mo</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 23 1957

9561 1 & 7087

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 *W. R. Allison*

Licensed Embalmer No. *44*

P. O. Address *Greenville*

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.