

THE DIVISION OF HEALTH OF MISSOURI
 FILED OCT 14 1955 STANDARD CERTIFICATE OF DEATH

31967

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 143

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give town) Sikeston	c. LENGTH OF STAY (in this place) 1 Day	c. CITY OR TOWN Canran	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 Mo. Delta Community Hospital		STREET ADDRESS (If rural, give location) ---	

3. NAME OF DECEASED (Type or Print) a. (First) Baby	b. (Middle) Girl	c. (Last) Jones	4. DATE OF DEATH (Month) (Day) (Year) 9 29 1955
---	-------------------------	------------------------	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 9-28-1955	9. AGE (In years last birthday) -	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 1 Hours - Min. -
----------------------	-------------------------------	---	-----------------------------------	--	---------------------------------	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 0	10b. KIND OF BUSINESS OR INDUSTRY 0	11. BIRTHPLACE (City and State or Foreign Country) Lilbourn, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	--	--

13a. FATHER'S NAME James Jones	13b. MOTHER'S MAIDEN NAME Dorothy Phillips	14. NAME OF HUSBAND OR WIFE 0
---------------------------------------	---	--------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 0	16. SOCIAL SECURITY NO. 0	17. INFORMANT'S SIGNATURE OR NAME Mr. James Jones, Canran, 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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 18 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Difficult delivery DUE TO (c) 9 55 D.O.		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 769.51		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 9-28, 1955, to 9-29, 1955, that I last saw the deceased alive on 9-29, 1955, and that death occurred at 12:50A m., from the causes and on the date stated above.

23a. SIGNATURE E. D. Urban M.D.	(Degree or title)	23b. ADDRESS Sikeston, Missouri	23c. DATE SIGNED 9/30/55
--	-------------------	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-29-55	24c. NAME OF CEMETERY OR CREMATORY Pleasant Hill	24d. LOCATION (City, town, or county) (State) Decaturville, Tenn.
--	--------------------------	---	--

DATE REC'D BY LOCAL REG. 10-3-55	REGISTRAR'S SIGNATURE Mr. E. H. Hunter	25. FUNERAL DIRECTOR'S SIGNATURE Ponder Funeral Home - Lilbourn Mo.	ADDRESS
---	---	--	---------

(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

DATE RECEIVED OCT 10 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1055-214

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 Not Embalmed F. L. Ponder

Licensed Embalmer No. 3367

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.