

FILED APR 2 - 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9900

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 229 PRIMARY REG. DIST. NO. 4343 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Florence Mo</u>		c. CITY OR TOWN <u>New Florence Mo</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>10 yr</u>		e. STREET ADDRESS (If rural, give location) <u>none</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Virgil</u>	b. (Middle) <u>Lesslie</u>	c. (Last) <u>Jones</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>3-27-1956</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>3-20-1881</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	-----------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Montgomery County Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
---	---	--	---

13a. FATHER'S NAME <u>William Jones</u>	13b. MOTHER'S MAIDEN NAME <u>Estician Harrell</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs Effie Jones</u>
---	---	--

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>no</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs William Zweifel New Florence Mo</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, ashenia, 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) <u>Acute DILATATION RT. VENTRICLE</u>		<u>4 hrs</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>CEREBRAL HAEMMORRHAGE</u>		<u>11 days</u>
DUE TO (c) <u>CHRONIC MYOCARDITIS</u>		<u>6 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>331x</u>
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>	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 Jan 15, 1952, to Mar. 27, 1956 that I last saw the deceased alive on 3-27, 1956, and that death occurred at 4 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>James O. Helm M.D.</u>	23b. ADDRESS <u>New Florence Mo</u>	23c. DATE SIGNED <u>3-29-56</u>
--	-------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3-29-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Montgomery City Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Montgomery City Mo</u>
---	--------------------------	--	---

DATE REC'D BY LOCAL REG. <u>3/30/56</u>	REGISTRAR'S SIGNATURE <u>Laura B Callaway</u>	FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Montgomery City Mo.</u>
---	---	---

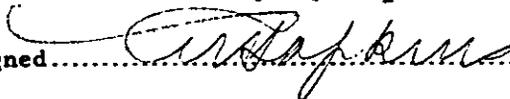
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb  
by me, ~~and~~ on the 27 th day of March 1956, Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

C. W. Hopkins  
Signed.....  


Licensed Embalmer No. 1487

P. O. Address Montgomery

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
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.