

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21114**

BIRTH NO. _____ REG. DIST. NO. **385** PRIMARY REG. DIST. NO. **3039** Registrar's No. **150**

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Lincoln	
b. CITY OR TOWN Marceline	c. LENGTH OF STAY (in this place) 3 weeks	c. CITY OR TOWN Callao	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 St. Francis Hosp.		e. STREET ADDRESS (If rural, give location) 66101	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Ezra	b. (Middle) Richard	c. (Last) Jones	6	18	56

5. SEX Male	6. COLOR OF RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 6-1-24	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR	IF UNDER 24 HRS.
					Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and State or Foreign Country) Callao Mo		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Richard Jones		13b. MOTHER'S MAIDEN NAME Isabel Ramey		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) no	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Stella William Callao Mo			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Longe Bowell	ANTECEDENT CAUSES			
	DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
	DUE TO (c) Pneumonia			
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 153X		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 **12-22, 1955** to **6-18, 1956**, that I last saw the deceased alive on **6-18, 1956**, and that death occurred at **7:45 AM** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert W. Smith MD	23b. ADDRESS Marceline, Mo	23c. DATE SIGNED 6-20-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-20/56	24c. NAME OF CEMETERY OR CREMATORY Concord Cem.	24d. LOCATION (City, town, or county) (State) Callao Mo
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DATE REC'D BY LOCAL REG. 6-19-56	REGISTRAR'S SIGNATURE Mary Jane Redgway	25 FUNERAL DIRECTOR'S SIGNATURE ADDRESS N. S. Edwards, Bevier Mo
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(Licensed Embalmer's Statement on Reverse Side)

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 *H. G. Edwards*

Licensed Embalmer No. *196*.....

P. O. Address *Brewer*

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.