

FILED NOV 14 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33301

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 294

1. PLACE OF DEATH a. COUNTY <u>CALLOWAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FULTON</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. CLAIR MO.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE HOSPITAL #1</u> Length of stay in lb <u>36 YRS</u>		d. STREET ADDRESS (If outside, give location) <u>—</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>JONES</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u> MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 21, 1868</u>	9. AGE (In years last birthday) <u>88</u> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK - FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>ST. CLAIR MO</u>
12. CITIZEN OF WHAT COUNTRY? <u>—</u>		13. FATHER'S NAME <u>BENJAMIN JONES</u>	
14. MOTHER'S MAIDEN NAME <u>HENRIETTA FOLEY</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 <u>RECORDS - 1941 Fulton Mo</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-VASCULAR-RENAL DISEASE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIO-SCLEROSIS</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>10 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>STATE HOSPITAL MAR. 2, 1930</u> to <u>NOV. 10, 1956</u> and last saw her alive on <u>NOV. 10, 1956</u> Death occurred at <u>5 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>H. J. Freund M.D.</u> (Degree or title)		22b. ADDRESS <u>STATE HOSPITAL #1</u>	
22c. DATE SIGNED <u>11/10/56</u>		23a. BURIAL, CREMATION, REMOVAL, (Specify)	
23b. DATE <u>NOV. 13, 1956</u>		23c. NAME OF CEMETERY OR CREMATORY <u>W.O.O.F. Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>St. Clair Mo.</u>		24. FUNERAL DIRECTOR <u>Carey - Smith</u> ADDRESS <u>St. Clair</u>	
25. DATE RECD. BY LOCAL REG. <u>NOV. 10 - 1956</u>		26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>	

Health,
Welfare
Public
Service300
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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(Licensed Embalmer's Statement on Reverse Side)

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.....
Henry G. Stewart

Licensed Embalmer No. *372*

P. O. Address *Fulton Mo*

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.