

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 18 1957

STATE FILE NUMBER

Registration District No. 215 Primary Registration District No. 4327 Registrar's No. 5

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Miller</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> <u>Miller</u> COUNTY |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Iberia</u>         |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <u>Iberia 0660</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Home</u> |  | Length of stay in lb   | d. STREET ADDRESS (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

|   |                               |   |   |   |   |
|---|-------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Michael</u> Middle <u>Dean</u> Last <u>Jones</u>                  |                               |   | 4. DATE OF DEATH<br>Month <u>Mar.</u> Day <u>5</u> Year <u>1957</u> |   |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 10, 1947</u>                           |   | 9. AGE (In years last birthday)<br><u>9</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Schoolchild</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (City and state or country)<br><u>Boonville, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |
| 13. FATHER'S NAME<br><u>Aaron L. Jones</u>  |                               |   | 14. MOTHER'S MAIDEN NAME<br><u>Alvis Lea Jones</u>                  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)         |                               | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br><u>Billy Wyrick Kansas City Mo.</u>                |   |   |

|   |  |  |  |   |
|---|--|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ANOXIC ANOXIA</u> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 MIN.</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |  |  |  | <u>8 MIN.</u>   |
| DUE TO (b) <u>ASPHYXIA</u>  |  |  |  | <u>15 MIN.</u>  |
| DUE TO (c) <u>INHALATION OF SMOKE</u>   |  |  |  | <u>9:16 C</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>16</u>           |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

|  |   |   |   |
|--|---|---|---|
| 20a. ACCIDENT <input checked="" 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.)<br><u>FIRE OF UNKNOWN ORIGIN IN HOME</u> |   |   |
| 20c. TIME OF INJURY<br><u>11:46 p.m.</u>   | Hour <u>3</u> Month <u>4</u> Year <u>57</u>   |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>    | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><u>Home</u>                              | 20f. CITY, TOWN, OR LOCATION<br><u>IBERIA</u> | 066 COUNTY <u>MILLER</u> STATE <u>MO.</u> |

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at 12:01 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

|  |  |                                     |
|--|--|-------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><u>L. S. Humphrey, D.O., Coroner</u> | 22b. ADDRESS<br><u>Wasscumbia, Mo.</u> | 22c. DATE SIGNED<br><u>3-9-1957</u> |
|--|--|-------------------------------------|

|  |                            |   |   |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>3/7/57</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Iberia</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Iberia Mo</u> |
|--|----------------------------|---|---|

|   |  |  |
|---|--|--|
| 24. FUNERAL DIRECTOR<br><u>Walter P. Wedges</u><br>Wedges Funeral Homes Inc Iberia, Mo. | 25. DATE RECD. BY LOCAL REG.<br><u>MARCH-13-57</u> | 26. REGISTRAR'S SIGNATURE<br><u>Jessie Perkins</u> |
|---|--|--|

Health, Welfare Public Service

300 / 1-56

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

1957

RECEIVED

MAR 15 '57

Miller County  
Health Department

MAR 27 1957

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 *Walter P. Hedger*

Licensed Embalmer No. *426*

P. O. Address *Zoria, 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.