

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9429

STATE FILE NUMBER

FILED MAR 18 1957

Registration District No. 215 Primary Registration District No. 4327 Registrar's No. 6

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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Miller</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Miller</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Iberia</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Iberia</u> <u>0660</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>Home</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ronald Gene Jones</u> First <u>Ronald</u> Middle <u>Gene</u> Last <u>Jones</u>			4. DATE OF DEATH <u>March 5, 1957</u> Month <u>March</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"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1942</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schoolchild</u>	100. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>15</u>	11. BIRTHPLACE (City and state or country) <u>Iberia, Mo</u>
13. FATHER'S NAME <u>Aaron L. Jones</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</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. <u>499423992</u>	14. MOTHER'S MAIDEN NAME. <u>Alvis Lea Wyrick</u>
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>ANOXIC ANOXIA</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ASPHYXIA</u> DUE TO (c) <u>INHALATION OF SMOKE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 MIN</u> <u>8 MIN.</u> <u>15 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>16</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
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.) <u>FIRE OF UNKNOWN ORIGIN IN HOME</u>		
20c. TIME OF INJURY <u>11:46</u> p.m. <u>3-4-57</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>IBERIA</u> COUNTY <u>MILLER</u> STATE <u>MO.</u>		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>12:01</u> A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>A. J. Humphreys, D.O. Coroner</u>		22b. ADDRESS <u>Luscumbia, Mo.</u>	
22c. DATE SIGNED <u>3-9-1957</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/7/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Iberia</u>	23d. LOCATION (City, town, or county) (State) <u>Iberia Mo</u>
24. FUNERAL DIRECTOR <u>Edges Funeral Homes Inc</u>		25. DATE RECD. BY LOCAL REG. <u>MARCH-13-57</u>	26. REGISTRAR'S SIGNATURE <u>Jessie Perkins</u>

1950

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 D. Hedges  
4265  
Licensed Embalmer No. \_\_\_\_\_

P. O. Address Thru, 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.