

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12134

STATE FILE NUMBER

FILED APR 22 1957

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 20

Health,  
Welfare  
Public  
Service

300  
1-56

All 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>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CENTRALIA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>CENTRALIA</u> <u>0100</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>Campbell Nursing Home</u> Length of stay in lb <u>4 days</u>		d. STREET ADDRESS (If outside, give location) <u>E. TARR ST.</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK WILLMER JONES</u> <small>First Middle Last</small>			4. DATE OF DEATH <u>APRIL-14-1957</u> <small>Month Day Year</small>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 11-1869</u>
9. AGE (In years last birthday) <u>88</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER</u>	11. BIRTHPLACE (City and state or country) <u>WISCONSIN</u>
13. FATHER'S NAME <u>George Morgan Jones</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rathburn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes Spanish American</u>		16. SOCIAL SECURITY NO. <u>322-18-4232</u>	17. INFORMANT <u>MRS. Helen Alton, Centralia, Mo.</u> <small>Address</small>
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>Cerebral Artery Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>332x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>Years</u>
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 <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>			
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>July 6/1956</u> to <u>April 12/1957</u> and last saw him alive on <u>April 19/1957</u> Death occurred at <u>2:30 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robt L. Ward M.D.</u>		22b. ADDRESS <u>Centralia, Mo</u>	22c. DATE SIGNED <u>4/14/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>April-16-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Wood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Chicago, Illinois</u>
24. FUNERAL DIRECTOR <u>Dave J. Ballou, Centralia, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>April 15-1957</u>	26. REGISTRAR'S SIGNATURE <u>Maud Mc Bride</u>

(Licensed Embalmer's Statement on Reverse Side)

APR 2 6 1957  
APR 2 4 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 *Paul J. Ballew* .....

Licensed Embalmer No. *4206*

P. O. Address *Centerville, 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.