

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

FILED MAY 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19850
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 88

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Vernon | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Vernon | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Nevada, Mo. | | c. CITY OR TOWN Nevada, Mo. | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Manlove Nursing Home (830 West Hunter St.) | | d. STREET ADDRESS Rural-R.F.D.No.3 | |
| Length of stay in 1b 7 months | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

| | | | | | |
|---|----------------------------------|--|--|--|---|
| 3. NAME OF DECEASED (Type or print) Ettie Iona Jones | | | 4. DATE OF DEATH Month May Day -12 Year 1957 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 28, 1863 | 9. AGE (In years last birthday) 94 | IF UNDER 1 YEAR Months 0 Days 15 |
| 10a. USUAL OCCUPATION (Give kind of business done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | 11. BIRTHPLACE (City and state or country) Wapello, Iowa | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Robert Craddock | | | 14. MOTHER'S MAIDEN NAME Elizabeth Watts | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT son Jay Jones, R.F.D.No.3-Nevada, Mo. | | |

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|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial failure | | INTERVAL BETWEEN ONSET AND DEATH 6 weeks |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Arteriosclerotic heart disease | 1 year |
| | DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4200 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 3 |

| | | |
|---|--|---|
| 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 4:00 Month May Day 12 Year 1957 | | |
| 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 **Sept 10, 1957** to **May 12 1957** and last saw her ^{her} _{alive} on **May 10 '57**
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Type or title)
Ray W. Kearsley, M.D.

22b. ADDRESS
Nevada, Mo.

22c. DATE SIGNED
5/14/57

| | | | |
|---|----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE May 14, 1957 | 23c. NAME OF CEMETERY OR CREMATORY Newton Burial Park | 23d. LOCATION (City, town, or county) (State) Nevada, Vernon, Missouri |
| 24. FUNERAL DIRECTOR ADDRESS Hays Funeral Service, Inc Nevada, Missouri | | 25. DATE RECD. BY LOCAL REG. 5-16-1957 | 26. REGISTRAR'S SIGNATURE Arnold J. Ferry |

(Licensed Embolmer'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 *H. H. Marmaduke*.....
Licensed Embalmer No. 207

P. O. Address *Florida*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (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.