

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

20739

State File No. _____

FILED JUN 17 1957

S. No. 300
v. 10.48

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>525-B</u>	
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>WRIGHT</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>		c. LENGTH OF STAY (In this place) <u>2-wks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MTN. GROVE, MO.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHNS HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>929 Maple ST. 1140</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u>		b. (Middle) <u>THOMAS</u>		c. (Last) <u>JONES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6-5-57</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>April 25, 1895</u>	
9. AGE (In years last birthday) <u>62</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 10 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SALE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>HANNIBAL MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM GRANT JONES</u>		13b. MOTHER'S MAIDEN NAME <u>NELLIE MAE WRIGHT</u>		14. NAME OF HUSBAND OR WIFE <u>MAVEL CLARK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W.T. 499-20-3804</u>		17. INFORMANT'S SIGNATURE AND NAME <u>Wm. L. Jones</u> ADDRESS <u>Springfield, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs.</u>
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ARTEROSCLEROTIC HEART DIS. WITH CONGESTIVE FAILURE</u>					
		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) _____					
		DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4200					
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>5-3-57</u> , 19 <u>57</u> , to <u>6/5/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/5/57</u> , 19 <u>57</u> , and that death occurred at <u>3:04 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Wm. L. Jones, M.D.</u>			(Degree or title) <u>0</u>		23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>6/8/57</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>6-5-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		24d. LOCATION (City, town, or county) (State) <u>MTN. GROVE MO</u>	
DATE REC'D BY LOCAL REG. <u>6-12-57</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>			25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>[Signature]</u>		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

JUN 18 1957

MAY 7 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

Student Embalmer

Signed

[Handwritten Signature]

Licensed Embalmer No. 3848

P. O. Address Mrs. Fry, 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 this body is not embalmed, fact should be so stated above.