

U. S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
STANDARD CERTIFICATE OF DEATH

State File No. **39488**

FILED DEC 2 - 1957

BIRTH NO. _____ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **36**

1. PLACE OF DEATH a. COUNTY CAPE GIRARDEAU		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY SCOTT	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CAPE GIRARDEAU		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ORAN	
c. LENGTH OF STAY (In this place) 3 WEEKS		d. STREET ADDRESS (If rural, give location) ORAN 1000⁰	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) COLETTA b. (Middle) BERTHA c. (Last) JONES			4. DATE OF DEATH (Month) (Day) (Year) NOV 28 1957		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH SEPT. 26 1909		9. AGE (In years last birthday) 52		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) ORAN, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A			

13a. FATHER'S NAME LOUIS B. HALTER		13b. MOTHER'S MAIDEN NAME MAGGIE MAE LETT		14. NAME OF HUSBAND OR WIFE ANSEL T. JONES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 48414-2837		17. INFORMANT'S SIGNATURE OR NAME ANSEL T. JONES ADDRESS ORAN, MO	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malignant Hypertension		INTERVAL BETWEEN ONSET AND DEATH app 5 yrs	
ANTECEDENT CAUSES		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.		445X			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., to 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 **12-21**, 19**56** to **11-23**, 19**57**, that I last saw the deceased alive on **11-23**, 19**57**, and that death occurred at **7:40^{PM}**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Harold Ridings MD		23b. ADDRESS Cape Girardeau, Mo.		23c. DATE SIGNED 11-26-57	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Nov. 25 1957		24c. NAME OF CEMETERY OR CREMATORY OLD GUARDIAN ANGELS	
24d. LOCATION (City, town, or county) (State) ORAN MO.		25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith		ADDRESS ORAN, MO.	
DATE REC'D BY LOCAL REG. 11-27-57		REGISTRAR'S SIGNATURE W. C. Summers			

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

44-0

MAR 31 1958

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Carl J. Smith

Signed.....

Student Embalmer

Licensed Embalmer No. 2676

P. O. Address. Orem 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.