

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45368
STATE FILE NUMBER

FILED DEC 30 1957

Registration District No. 290 Primary Registration District No. 5985 Registrar's No. 165

Health,
& Welfare
S. Public
th Service

S. 300
v. 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 Pulaski				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Missouri b. COUNTY Pulaski			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ft Leonard Wood			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Dixon		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 S Army Hospital			Length of stay in lb 2 days	d. STREET ADDRESS none			(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Anne <i>First</i> C <i>Middle</i> Jones <i>Last</i>				4. DATE OF DEATH Dec 15 1957		Month Dec Day 15 Year 1957	
5. SEX Female	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 July 1957		9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 5 Days 14 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Pulaski County Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David M. Jones				14. MOTHER'S MAIDEN NAME Doris C Hershberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT David M Jones Address Dixon, Missouri			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Congenital heart disease					
		DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT <input type="checkbox"/> WORK AT WORK		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 13 Dec 57 to 15 Dec 57 and last saw her her her alive on 14 Dec 57 Death occurred at 2:05 A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Ralph A. Shagart J. Mal (Degree or title) 0				22b. ADDRESS U S Army Hospital Ft Wood Mo		22c. DATE SIGNED 15 Dec 57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-16-57	23c. NAME OF CEMETERY OR CREMATORY Unknown		23d. LOCATION (City, town, or county) (State) Newton Kansas		
24. FUNERAL DIRECTOR Belle Jr Hedges Address Hedges funeral Homes Inc Crocker Mo			25. DATE RECD. BY LOCAL REG. 12-16-57		26. REGISTRAR'S SIGNATURE Paul Rae Anderson		

(Licensed Embalmer's Statement on Reverse Side)

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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 *Clarence Moss*.....

Licensed Embalmer No. *4896*

P. O. Address *H. Reynoldsville*

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.