

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 27 1958

1021
STATE FILE NUMBER
Registar's No. 51A

Registration District No. 128 Primary Registration District No. 5465

300
-57
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1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina COUNTY Berkeley	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural, N. Campbell Tswp		c. CITY OR TOWN Mt Holly	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mt E Springfield, Mo on Hwy 66		d. STREET ADDRESS (If outside, give location) P O Box 5	
3. NAME OF DECEASED (Type or print) JAMES		4. DATE OF DEATH January 12 1958	
5. SEX Male		6. COLOR OR RACE Negroid	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 May 1920	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		11. BIRTHPLACE (City and state or country) Branchville, S. Carolina	
10b. KIND OF BUSINESS OR INDUSTRY US Army		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Deceased		13b. MOTHER'S MAIDEN NAME Deceased	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give age or dates of service) Yes 15 yrs		16. SOCIAL SECURITY NO. 248-16-6374	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Spontaneous, Pons of Brain Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Spontaneous, Pons of Brain DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) UNATTENDED BY A PHYSICIAN	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <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 _____ to _____ and last saw her alive on _____ Death occurred at Approx 3:00 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James P. Jones M.D. (Degree or title) _____		22b. ADDRESS Greene County Court House Springfield, Missouri	
23a. BURNIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-14-58	
23c. NAME OF CEMETERY OR CREMATORY Unknown		23d. LOCATION (City, town, or county) (State) Charleston, So. Carolina	
24. FUNERAL DIRECTOR Hedges Funeral Homes ADDRESS _____		25. DATE RECD. BY LOCAL REG. 1-16-58	
26. REGISTRAR'S SIGNATURE Effie S. Melton			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be traced. All diseases in Part I must be causally related.

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 *Waynesville, N.C.*

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.