

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019105
STATE FILE NUMBER

FILED JUN 9 1958 Registration District No. 239 Primary Registration District No. 5825 Registrar's No. 15

| | | | |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY NEW MADRID | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY New Madrid | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN COMO | | c. CITY OR TOWN Malden, Mo. 0720 | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4 1/2 Mi. N.E. Malden | | d. STREET ADDRESS (If outside, give location) 4 1/2 Mi. N.E. Malden | |
| Length of stay in lb 50 Yrs. | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ELLIS ANDERSON JONES | | | 4. DATE OF DEATH Month Day Year MAY 16 1958 |
| 5. SEX male <input type="checkbox"/> female <input checked="" type="checkbox"/> | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-22-1875 |
| 9. AGE (In years last birthday) 83 | | 10. USUAL OCCUPATION (Give kind of work done during last year of life, even if retired) FARMING | 11. BIRTHPLACE (City and state or country) MALTA BEND, Mo. 0 |
| 12. CITIZEN OF WHAT COUNTRY? U.S. A. | | 13. NAME OF HUSBAND OR WIFE MAY JONES | |
| 13a. FATHER'S NAME CALEB J. W. JONES | | 13b. MOTHER'S MAIDEN NAME SARAH E. ANDERSON | |
| 14. NAME OF DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> unknown) (If yes, war or dates of service) NO. | | 16. SOCIAL SECURITY NO. 496-40-1156 | |
| 17. INFORMANT MAY JONES, PARMA, Mo. Route 1 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>M. g. corditis. Coringia attacks</i> DUE TO (b) <i>Bed rest with arthritis for 2 yrs and</i> DUE TO (c) <i>Advanced attacks of nephritis.</i> | | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs |
| 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 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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20e. CITY, TOWN, OR LOCATION COUNTY STATE | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from Death occurred at 4:00 P.M. July 55 to May 16-58 and last saw her/him alive on May 14-58 on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>Dr. G. W. Husted</i> (Degree or title) | | 22b. ADDRESS MALDEN, Mo. | |
| 22c. DATE SIGNED 5/19/58 | | | |
| 23a. BURIAL, CREMATION, REBURYAL (Specify) BURIAL | | 23b. DATE 5-18-58 | |
| 23c. NAME OF CEMETERY OR CREMATORY PARK | | 23d. LOCATION (City, town, or county) (State) MALDEN, MO. | |
| 24. FUNERAL DIRECTOR DAY FUNERAL HOME, MALDEN, MO. | | 25. DATE RECD. BY LOCAL REG. 5/20/58 | |
| 26. REGISTRAR'S SIGNATURE <i>Dr. G. W. Husted, M.D.</i> | | | |

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Color, contour, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

217

DATE RECEIVED MAY 27 1958
NEW MADRID CO. HEALTH CENTER

E. J.

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 J. W. Schuman

Licensed Embalmer No. 4086

P. O. Address Malden

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.