

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-039553  
STATE FILE NUMBER

FILED DEC 1 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1074A

300 4  
1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Buffalo</u> 0310
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Interlocking Home</u>		Length of stay in 1b <u>4 mos.</u>	d. STREET ADDRESS (If outside, give location) <u>E. Benton St.</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <u>REBECCA JANE JONES</u>			4. DATE OF DEATH Month Day Year <u>NOV - 6 - 1958</u>		
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-30-1876</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	11. BIRTHPLACE (City and state or country) <u>Louisburg Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Atlas M. Jones</u>	13b. MOTHER'S MAIDEN NAME <u>Amanda E. Boss</u>	14. NAME OF HUSBAND OR WIFE <u>✓</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>332X</u>	17. INFORMANT Address <u>Francis Jones Buffalo Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> 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 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from <u>Oct 27<sup>th</sup> 1958</u> to <u>11-6-58</u> and last saw her alive on <u>11-4-58</u> Death occurred at <u>11-6-58</u> <u>12:45 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Walter P. Simpson, M.D.</u>	22b. ADDRESS <u>Springfield Med Bldg Springfield Mo.</u>	22c. DATE SIGNED <u>11-26-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>11-8-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Louisburg cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Louisburg, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>L.B. Jones Buffalo Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-28-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 me....., Student Embalmer No. ✓..... working under my personal supervision.

Student ✓.....  
Signature of Student Embalmer

Signed R.E. Cleathorn.....

Licensed Embalmer No. 3813.....

P. O. Address Buffalo, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.