

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045066

STATE FILE NUMBER

FILED DEC 23 1958

Registration District No. 264 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Ozark</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Ozark</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Big Creek Twp.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Dugginsville 0770</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>None</u>			Length of stay in lb <u>Life</u>	d. STREET ADDRESS <u>Big Creek Twp.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>I.</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>12</u> Day <u>-14-</u> Year <u>58</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-23-82</u>		9. AGE (In years last birthday) <u>76</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>		11. BIRTHPLACE (City and state or country) <u>Honeyland Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Jones</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>				
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>512-24665</u>		17. INFORMANT Address <u>Joe Jones Dugginsville</u>				
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>Uremia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Intermittent Hepatitis</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) <u>594X</u>							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 _____ a. m. _____ p. m. _____ Month, Day, Year _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>4-26-1956</u> to <u>12-14-58</u> and last saw ^{from} him alive on <u>12-12-58</u> Death occurred at <u>1:05 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>M. J. Haernew DD²</u>				22b. ADDRESS <u>Dugginsville, Mo</u>		22c. DATE SIGNED <u>12-18-58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>12-18-58</u>	<u>HART</u>		<u>Ozark Co. Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Clintyhead Dugginsville</u>				25. DATE RECD. BY LOCAL REG. <u>12-20-58</u>		26. REGISTRAR'S SIGNATURE <u>Thana Mahan</u>		

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 examined
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John P. Usrey*
.....

Licensed Embalmer No. *248*

P. O. Address *.....*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.