

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001769

STATE FILE NUMBER

FILED FEB 4 1959

Registration District No. 157

Primary Registration District No. 2028

Registrar's No. 26

300 P
1-57

1. PLACE OF DEATH a. COUNTY <u>Dasher</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dasher</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carthage</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Carthage</u> ⁰⁴⁹³ 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>204 Bois d'Arc</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>204 Bois d'Arc</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First - Middle Last <u>Clain</u> <u>Jumbo</u>			4. DATE OF DEATH Month Day Year <u>Jan. 24, 1959</u>
5. SEX <u>Male</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>March 4, 1880</u>
9. AGE (In years last birthday) <u>78</u>		10. FUNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ret'd</u>	11. BIRTHPLACE (City and state or country) <u>Endicopolis, Ind.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Unknown</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE	
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>490-10-1137</u>	17. INFORMANT Address <u>Clara Johnson, Carthage, Mo</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>Pneumonia, Bronchial</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis general</u> DUE TO <u>Cerebral hemorrhage with paralysis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) <u>331X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 <u>5-18-53</u> to <u>Jan. 24, 59</u> and last saw her alive on <u>1-23-59</u> Death occurred at <u>at home</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George H. Wood M.D.</u>		22b. ADDRESS <u>Carthage, Mo</u>	
22c. DATE SIGNED <u>1-26-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	
23b. DATE <u>-107-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Carthage Cemetery</u>	
23d. LOCATION (City, town, or country) (State) <u>Carthage, Mo</u>		24. FUNERAL DIRECTOR ADDRESS <u>Werner Funeral Home, Carthage, Mo</u>	
25. DATE RECD. BY LOCAL REG. <u>1-26-59</u>		26. REGISTRAR'S SIGNATURE <u>EM Clinton</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secretary, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. 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

Licensed Embalmer No.....

P. O. Address.....

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.