

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001918

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. _____ Registrar's No. 12

FEB 3 1959

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| 1. PLACE OF DEATH a. COUNTY <u>Laclede</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington T.S.</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>Lebanon</u> <u>530</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>8 Miles S. 5 H.W.</u> | | Length of stay in lb <u>7 Days</u> | d. STREET ADDRESS (If outside, give location) <u>Rt. 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>WILLARD</u> Middle <u>-</u> Last <u>JONES JR.</u> | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>18,</u> Year <u>1959</u> |
| 5. SEX <u>Male</u> <input checked="" type="checkbox"/> | 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>Oct. 2, 1955</u> |
| 9. AGE (In years last birthday) <u>3</u> | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None.</u> | 11. BIRTHPLACE (City and state or country) <u>Laclede County Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>Willard Jones Sr.</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Norma Dinwitty</u> | | 14. NAME OF HUSBAND OR WIFE <u>None.</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>None.</u> | 17. INFORMANT Address <u>Mr. Willard Jones Sr. Lebanon, 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>Exposure</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>24-36 Hrs.</u> |
| DUE TO (b) <u>Being lost in the woods.</u> | | | <u>9321</u> <u>46</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 checked="" 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.) <u>wandered away from farm home and became lost.</u> | | |
| 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 checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Farm</u> | 20f. CITY, TOWN, OR LOCATION COUNTY <u>653</u> STATE <u>Lebanon Rt. 1 Laclede Missouri</u> | |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>1:00 A.M.</u> to <u>1:00 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>L.P. Palmer</u> (Degree or title) <u>Coroner 3</u> | 22b. ADDRESS <u>Lebanon, Mo.</u> | | 22c. DATE SIGNED <u>1/26/59</u> |
| 23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u> | 23b. DATE <u>1/27/59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>White Oak Pond Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Laclede County Missouri</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>S. R. Palmer Lebanon, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>1-27-1959</u> | 26. REGISTRAR'S SIGNATURE <u>Hella L. Day</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300

-57/

FEB 8 1958

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 *Stanley's K Palmer*

Licensed Embalmer No. *4810*

P. O. Address *Lebanon, 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.