

FILED FEB 16 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005161

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 154

300
1-57

All diseases in Part I must be causally related.

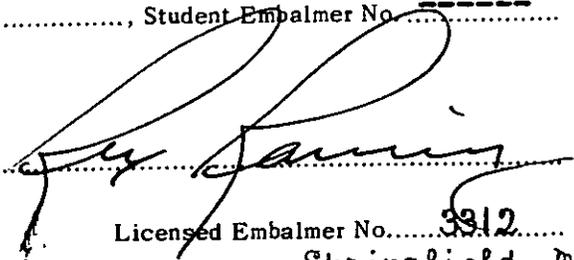
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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>Greene</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>Springfield</u> ⁶³⁹⁰ _c 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>D.O.U. St. John Hosp.</u> Length of stay in lb <u>1 yr.</u>		d. STREET ADDRESS (If outside, give location) <u>Route 3</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joby</u> Middle <u>Berry</u> Last <u>Jones</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>13,</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>Feb. 18, 1889</u>
9. AGE (In years last birthday) <u>69</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>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (City and state or country) <u>Newton County, Ark.</u>
12. CITIZENSHIP OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>John H. Jones</u>	
13b. MOTHER'S MAIDEN NAME <u>Frances Ann Key</u>		14. NAME OF HUSBAND OR WIFE <u>Virginia Frances Jones (Dec.)</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>557-12-0161</u>	17. INFORMANT (Son) Address <u>John F. Jones - Springfield, 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>Probable Coronary Occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ <u>UNATTENDED BY PHYSICIAN</u>			
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.) <u>4201</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 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 _____ and last saw her/him alive on _____ Death occurred at <u>1:45 a.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22. SIGNATURE <u>James F. Jones</u> (Degree or title) <u>Director - City County Health Dept</u>		22a. ADDRESS <u>Court House, Springfield, Mo</u>	22c. DATE SIGNED <u>2-13-59</u>
23a. BURIAL, CREMATION, or other final disposition (Specify) <u>burial</u>	23b. DATE <u>2-15, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Proton Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Proton, Missouri</u>
24. FUNERAL DIRECTOR <u>Rex Ranney - Springfield, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>2-12-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>

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. 3312
P. O. Address Springfield, 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.