

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008409
STATE FILE NUMBER

FULL MAR 23 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 122

300
-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Grovesprings</u> 1140
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ellis Fischel State Cancer Hosp.</u>		Length of stay in lb <u>11 da.</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Weco</u> Middle <u>Homer</u> Last <u>Jones</u>			4. DATE OF DEATH Month <u>3</u> - Day <u>18</u> Year <u>1959</u>	
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-3-1899</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months _____ Days _____	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>laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Grovesprings, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William D. Jones</u>	13b. MOTHER'S MAIDEN NAME <u>Adeline Webb</u>	14. NAME OF HUSBAND OR WIFE <u>Gladys Jones</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>Unknown</u>	16. SOCIAL SECURITY NO. <u>487-24-1628</u>	17. INFORMANT <u>Hospital Records</u> Address <u>Hi Way 40 + Garth.</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>Carcinoma of the Bladder</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ 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 checked="" type="checkbox"/> NO <input 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>1810</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		

20d. INJURY OCCURRED WHILE AT <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 <u>Hartsville</u>	COUNTY _____	STATE _____
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21. I attended the deceased from March 6 1959 to March 18 1959 and last saw him alive on March 18, 1959
Death occurred at 4:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>C. M. Chase</u> (Degree or title) <u>Internist</u>	22b. ADDRESS <u>Ellis Fischel Hosp. Columbia</u>	22c. DATE SIGNED <u>Mar 18, 1959</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Max 18, 1959</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Hartsville</u>	23d. LOCATION (City, town, or county) (State) <u>Mo</u>
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24. FUNERAL DIRECTOR <u>Walter Simpson</u> ADDRESS <u>Hartsville Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Max 18 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in Part I - no symptoms with de-cause related. All diseases in Part I must be causally related.

VS FEB 19 1960

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. 574..... working under my personal supervision.

Student Warren Simpson
Signature of Student Embalmer

Signed

Licensed Embalmer No.....

P. O. Address Box 182 Hart

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.