

Health, Welfare & Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008606

STATE FILE NUMBER

APR 10 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 102

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57

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Ethel</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTIONS <u>State Hospital #1</u>		Length of stay in 1b <u>36yrs. 5mos.</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>COMMODORE</u> Middle <u>HOWARD</u> Last <u>JONES</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>4</u> Year <u>1959</u>		
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>10-25-1882</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.
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>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Ethel, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Christopher H. Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jane Ratcliff</u>	14. NAME OF HUSBAND OR WIFE <u>Florence M. Jones</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>unk. - none</u>	17. INFORMANT Address <u>State Hospital No. 1; Fulton, Missouri</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>MYOCARDIAL FAILURE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>					<u>15 years</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>4200</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 <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	
St. Hosp. #1 He attended the deceased from <u>11-17-1922</u> to <u>4-4-1959</u> Death occurred at <u>2:05 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Harold G. Freund</u> (Degree or title)			22b. ADDRESS <u>State Hospital #1; Fulton, Mo.</u>		22c. DATE SIGNED <u>4-4-59</u>
23a. BURIAL (CREMATION, REMOVE) (Specify) <u>Burial</u>	23b. DATE <u>April 6, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Heltan Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Goldsberg, Mo.</u>	
24. FUNERAL DIRECTOR <u>Morgan Funeral Home, Fulton, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>April 9-1959</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)

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 *Marshall C. Blackwell*

Licensed Embalmer No. *4713*  
P. O. Address *Fullton, m.c.*

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.