

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016663
STATE FILE NUMBER

FILED JUN 1 1959 Registration District No. 13 Primary Registration District No. 3003 Registrar's No. 74

1. PLACE OF DEATH a. COUNTY BARRY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY BARRY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MONETT		c. CITY OR TOWN MONETT	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SCROGGINS NURSE HOME 4 Yrs		d. STREET ADDRESS (If outside, give location) 910 5th. Street	
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE MAUDE JONES			4. DATE OF DEATH Month Day Year May 18, 1959
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> a. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Chester, Ill.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Henry Clay Woods	
13b. MOTHER'S MAIDEN NAME Unknown		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) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Nursing Home records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma.			INTERVAL BETWEEN ONSET AND DEATH 20 Hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Diabetes			DUE TO (c) Unknown.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 2.60X			
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 3-4-59		COUNTY STATE 5-9-59	
21. I attended the deceased from 8:35 P. to 5-9-59 and last saw her ^{him} alive on 5-9-59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Charles Moore D.O. (Degree or title)		22b. ADDRESS Price City Mo.	
22c. DATE SIGNED 5-21-59.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 5-21-59		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
23d. LOCATION (City, town, or county) Cassville, Mo.		(State)	
24. FUNERAL DIRECTOR Doyle E. Williamson, Cassville, Mo.		25. DATE RECD. BY LOCAL REG. 5-23-59	
26. REGISTRAR'S SIGNATURE Mrs P.N. Cook			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

300
-57

4

MEDICAL CERTIFICATION

3
0

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 *Dr. S. J. Williams*

Licensed Embalmer No. *4883*

P. O. Address *Cassville*

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.