

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017356
STATE FILE NUMBER

FILED MAY 25 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 458 D

300
1-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Leade	
b. CITY (If outside corporate limits, give TOWNSHIP only) Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Lebanon Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital D.O.A.		Length of stay in lb D.O.A.	d. STREET (If outside, give location) ADDRESS 412 S. Jackson Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First EARL Middle JEFFERSON Last JONES			4. DATE OF DEATH Month may Day 6 Year 1959		
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5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1899	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer & merchant	10b. KIND OF BUSINESS OR INDUSTRY farmer & merchant	11. BIRTHPLACE (City and state or country) Grovespring, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Leybourn Jones	13b. MOTHER'S MAIDEN NAME Mattie Webb	14. NAME OF HUSBAND OR WIFE Edna Jones
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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) no none	16. SOCIAL SECURITY NO. 491-12-1284	17. INFORMANT Dr. Gene W. Farthing,	Address Springfield, Mo.
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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) Uremia		INTERVAL BETWEEN ONSET AND DEATH 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Stage four kidney, right		months
DUE TO (c) Arteriosclerotic ulcer		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 602X		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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
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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 Lebanon,	COUNTY Mo.	STATE
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21. I attended the deceased from 4-1-59 to 5-6-59 and last saw him alive on 5-6-59 Death occurred at 8:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Louis E. Joad (Degree or title) MD.	22b. ADDRESS Lebanon, Mo.	22c. DATE SIGNED 5-12-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 5-10-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Rose Memorial Park	23d. LOCATION (City, town, or county) Lebanon,	(State) Mo.
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24. FUNERAL DIRECTOR H. J. Shad	ADDRESS Lebanon, Mo.	25. DATE RECD. BY LOCAL REG. 5-18-59	26. REGISTRAR'S SIGNATURE Effie S. Melton
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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.: most use only standard nomenclature in item 18. No symptoms with no history. All diseases in Part I must be causally related.

MAR 1 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. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *R. W. Barber*

Licensed Embalmer No. *2848*

P. O. Address *W. C. Guss*

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.