

(STEVE PARKER'S)

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021888
STATE FILE NUMBER

FILED JUN 30 1959

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 313

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE OKLAHOMA b. COUNTY OTTAWA	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JOPLIN		c. CITY OR TOWN MIAMI 3350	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		d. STREET ADDRESS (If outside, give location) 229 L. S.E.	
3. NAME OF DECEASED (Type or print) First Middle Last EVERETT JONES		4. DATE OF DEATH Month Day Year JUNE 21, 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 2, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME JAMES JONES		13b. MOTHER'S MAIDEN NAME CYNTHIA MORGAN	14. NAME OF HUSBAND OR WIFE SARAH JONES,
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. 441-16-8054	17. INFORMANT Address MRS. SARAH JONES, MIAMI, OKLAHOMA
18. CAUSE OF DEATH (Enter only one cause per line for (a); (b); and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right heart failure, acute + chronic DUE TO (b) Atelectasis, pulmonary edema. DUE TO (c) Slightly liver			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Slightly liver			19. WAS AUTOPSY PERFORMED? 1 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.)	
20c. TIME OF INJURY Hour Month, Day, Year 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 COUNTY STATE
21. I attended the deceased from 20 June 59 to 21 June 59 and last saw her alive on 21 June 59 Death occurred at 4:05 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dorcas H. Burrows		22b. ADDRESS 6 205 Medical Arts Bldg. JOPLIN, MO.	22c. DATE SIGNED 21 June 59.
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 6-24-59	23c. NAME OF CEMETERY OR CREMATORY G.A.R. CEMETERY,	23d. LOCATION (City, town, or county) (State) MIAMI, OKLAHOMA
24. FUNERAL DIRECTOR ADDRESS BURKS FUNERAL HOME, AFTON, OKLAHOMA		25. DATE RECD. BY LOCAL REG. 6-25-1959	26. REGISTRAR'S SIGNATURE Dorcas Merriam

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *F. M. Jones*

Licensed Embalmer No. *7319*

P. O. Address *Joplin 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.