

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-021920

FILED JUL 8 1959 / 57

3028

133

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jasper	a. STATE Missouri b. COUNTY Jasper		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage	Length of stay in 1b 28 yrs	c. CITY OR TOWN Carthage	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks hospital	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 610 Morningside Drive	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First CARMEN	Middle ERCEL	Last JONES	4. DATE OF DEATH	Month June	Day 28,	Year 1959
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5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1887	9. AGE (last birthday) 72	IF UNDER 1 YEAR	IF UNDER 24 HR
			Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired housewife	10b. KIND OF BUSINESS OR INDUSTRY domestic	11. BIRTHPLACE (City and state or country) Arkansas Mammouth Springs	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME William Wright	13b. MOTHER'S MAIDEN NAME Elizabeth Kisse	14. NAME OF HUSBAND OR WIFE Frank 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	16. SOCIAL SECURITY NO. none	17. INFORMANT Don Jones, Route 3, Carthage, 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) Myocardial infarction	INTERVAL BETWEEN ONSET AND DEATH 13 days
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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 _____ a.m. _____ p.m. Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from 8-14-51 **to** 6-28-59 **and last saw her** 6-28-59 **alive on**
Death occurred at 4:42 **p** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>M. Foster White</i> (Degree or title) M.D.	22b. ADDRESS 616 W. Centennial Carthage, Mo	22c. DATE SIGNED 6-29-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 6-30-59	23c. NAME OF CEMETERY OR CREMATORY Forest Park Cemetery	23d. LOCATION (City, town, or county) Joplin, Mo	(State)
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24. FUNERAL DIRECTOR KNELL MORTUARY	ADDRESS Carthage, Mo	25. DATE RECD. BY LOCAL REG. 6-30-59	26. REGISTRAR'S SIGNATURE <i>W. Hunter</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Robert H. Knell

Licensed Embalmer No. 4459

P. O. Address Carthage, M

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.