

FILED VS JUL 22 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-024657

STATE FILE NUMBER

Registration District No. 104 Primary Registration District No. 4176 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <u>DUNKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>DUNKLIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MALDEN</u>		c. CITY OR TOWN <u>MALDEN</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>107 OZARK</u>		d. STREET ADDRESS (If outside, give location) <u>107 OZARK</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADDIE EMMALINE JONT</u>		4. DATE OF DEATH Month Day Year <u>JULY 12, 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 10, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WORK</u>	11. BIRTHPLACE (City and state or country) <u>NEW MADRID MO</u>
13a. FATHER'S NAME <u>MICHAEL TOWEY</u>		14. NAME OF HUSBAND OR WIFE <u>THOMAS F. JONT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		17. INFORMANT Address <u>MARY DOWNING (Daughter) MALDEN MO</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>Cerebral hemorrhage.</u> Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) <u>Coronary Arteriosclerosis</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>331X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>30 years</u>
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.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>5-18-59</u> to <u>7-12-59</u> and last saw her alive on <u>7-11-59</u> Death occurred at <u>11:42</u> <u>P</u> on the date stated above; and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>7-13-59</u>	
22a. SIGNATURE (Degree or title) <u>Maude Croan M.D.</u>		22b. ADDRESS <u>500 N. Douglas, Malden Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JULY 15, 1959</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PARK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MALDEN MO</u>	
24. FUNERAL DIRECTOR <u>DAY & KNIGHT, F.H.</u>		25. DATE RECD. BY LOCAL REG. <u>7-16-59</u>	
26. REGISTRAR'S SIGNATURE <u>J. L. Schuman</u>			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

IDENTITY FILE NUMBER 158-211

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 *J. E. Schuman*.....
Licensed Embalmer No. *4086*.....

P. O. Address *Madden*.....

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.