

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 7 1959

59-024667

STATE FILE NUMBER

Registration District No. 109 Primary Registration District No. 5424 Registrar's No. 30

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| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Dunklin</u><br>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Campbell</u> Length of stay in 1b _____<br>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Route 1</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Dunklin</u><br>c. CITY OR TOWN <u>Campbell</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/><br>d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
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|---|---|---|--|---|---|---|--|
| <b>3. NAME OF DECEASED</b> (Type or print) First Middle Last<br><u>Robert Ray Jones</u>                         |   |   | <b>4. DATE OF DEATH</b> Month Day Year<br><u>7-13-1959</u> |   |   |   |  |
| <b>5. SEX</b><br><u>male</u>  | <b>6. COLOR OR RACE</b><br><u>White</u> | <b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/><br><b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>7-13-1959</u>                | <b>9. AGE (last birthday)</b><br>IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours <u>1</u> Min. <u>30</u> |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)              |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |  | <b>11. BIRTHPLACE</b> (City and state or country) <u>Campbell, Mo.</u>      |   | <b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u> |  |
| <b>13a. FATHER'S NAME</b><br><u>William Calvin Jones</u>  |   | <b>13b. MOTHER'S MAIDEN NAME</b><br><u>Nona Murray</u>  |  | <b>14. NAME OF HUSBAND OR WIFE</b>  |   |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) |   | <b>16. SOCIAL SECURITY NO.</b>  |  | <b>17. INFORMANT</b> Address<br><u>William C. Jones-Campbell, Mo.</u>       |   |   |  |

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| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Premature birth</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) _____<br>DUE TO (c) _____ |  | 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)  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |

|   |  |   |  |
|---|--|---|--|
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        | <b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/> | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)   |  |
| <b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____  |  |   |  |
| <b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ |  |
| <b>20f. CITY, TOWN, OR LOCATION</b> _____   |  | <b>COUNTY</b> _____ <b>STATE</b> _____  |  |

21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at 6:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|--|---|--|---|--|
| <b>22a. SIGNATURE</b> (Degree or title)<br><u>Bryan L. Franklin, M.D.</u>          |  | <b>22b. ADDRESS</b><br><u>Mo. Campbell, Mo. Rt. 1</u> |  | <b>22c. DATE SIGNED</b><br><u>7-14-59</u>                   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>                  |  | <b>23b. DATE</b><br><u>7-13-1959</u>                  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Bethany</u> |  |
| <b>23d. LOCATION</b> (City, town, or county) (State)<br><u>Campbell, Mo. Rt. 1</u> |  |   |  |   |  |

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|--|--|---|--|---|--|
| <b>24. FUNERAL DIRECTOR</b> ADDRESS<br><u>McDaniel Funeral Ser.-Kennett, Mo.</u> |  | <b>25. DATE RECD. BY LOCAL REG.</b><br><u>7-27-59</u> |  | <b>26. REGISTRAR'S SIGNATURE</b><br><u>Mrs. Bental Campbell</u> |  |
|--|--|---|--|---|--|

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Tommy D. Dote

Licensed Embalmer No. 4886

P. O. Address Kennerly

Note: The above **MUST BE SIGNED** BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.