

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028190

FILED VS SEP 8 1959 38

Registration District No. 38 Primary Registration District No. 5120 Registrar's No. 413

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mississ</u> b. COUNTY <u>Boone</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>3 yrs.</u>	c. CITY OR TOWN <u>Columbia</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RFD 1</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RFD 1</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZA</u> Last <u>JONES</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>1</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negs</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>Jan. 8, 1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Callaway Co., Mo. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Joe Scott</u>		13b. MOTHER'S MAIDEN NAME <u>Lizzie Walker</u>		14. NAME OF HUSBAND OR WIFE <u>Walter Jones</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>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Rosetta Williams, Columbia, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>CEREBRAL ANOXIA</u>					<u>14-18 HRS.</u> <u>YEARS.</u>
DUE TO (b) <u>CEREBRAL ARTERIAL OCCLUSION</u>					
DUE TO (c) <u>ARTERIOSCLEROTIC DEGENERATION</u>					
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
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
21. I attended the deceased from <u>AUG. 31 1959</u> to <u>same date</u> and last saw her/him alive on <u>AUG. 31, 59</u> Death occurred at <u>APPROX. MIDNIGHT</u> on the date stated above, and to the best of my knowledge, from the causes stated. <u>PATIENT WAS DECEASED WHEN EXAMINED AT 12:00 AM 9-1-59.</u>					
22a. SIGNATURE (Degree or title) <u>John Chole Stokdale M.D.</u>			22b. ADDRESS <u>11 So. 8th St.</u>		22c. DATE SIGNED <u>9-2-59.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>Sept 5, 1959</u>	<u>C, Albany</u>		<u>Columbia, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Mrs. Stuart Parker, Columbia, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Sept 3 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</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 by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed George A. Swannick

Licensed Embalmer No. 4425

P. O. Address Columbus, Ga.

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