

# R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-028588

FILED VS SEP 1 1959

Registration District No. 100 Primary Registration District No. \_\_\_\_\_ Registrar's No. 61

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dent</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gladden typ</u>		Length of stay in lb <u>94 yrs</u>		c. CITY OR TOWN <u>Salem</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Jadwin route</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Minerva</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>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>Feb 11 1865</u>	9. AGE (last birthday) <u>94</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>x</u>		11. BIRTHPLACE (City and state or country) <u>Dent County Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>T. Jones</u>			13b. MOTHER'S MAIDEN NAME <u>Minerva Wilson</u>			14. NAME OF HUSBAND OR WIFE <u>T.D. 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>x</u>		17. INFORMANT Address <u>Mrs John Leonard rt # Salem 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>Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
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	
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 _____ a.m. _____ p.m.		Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>November 3 1954</u> , to <u>8-25-59</u> and last saw her/him alive on <u>8-24-59</u> Death occurred at <u>8:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>[Signature]</u>				22b. ADDRESS <u>Salem, Mo.</u>		22c. DATE SIGNED <u>8-26-5</u>	
23a. BURIAL, CREMATION, REPOSS. (Specify) <u>burial</u>		23b. DATE <u>8-29-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Dent County Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Spencer Funeral Home Inc</u>			25. DATE RECD. BY LOCAL REG. <u>8/26/59</u>		26. REGISTRAR'S SIGNATURE <u>M. M. Hart, M.D. by [Signature]</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 Carl H. Spitzer

Licensed Embalmer No. 237

P. O. Address Palmer

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

SEP 9 195