

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032937

FILED VS. OCT 13 1959

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 99

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Lawrence</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lawrence</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Aurora</b>		Length of stay in 1b <b>Years</b>		c. CITY OR TOWN <b>Aurora</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>930 S. Madison</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>930 S. Madison</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>ELIZABETH</b> Last <b>JONES</b>				4. DATE OF DEATH Month <b>October</b> Day <b>4</b> Year <b>1959</b>						
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5/25/75</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Lawrence Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13a. FATHER'S NAME <b>James Durham</b>			13b. MOTHER'S MAIDEN NAME <b>Elizabeth Jennings</b>			14. NAME OF HUSBAND OR WIFE <b>David M. Jones</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>David M. Jones; Aurora, Mo.</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>			
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 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 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 <b>9/1/58</b> to <b>10/3/59</b> and last saw him alive on <b>10/3/59</b> Death occurred at <b>1:00 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <i>A. Morrison MD</i> (Degree or title)				22b. ADDRESS <b>Aurora, Mo.</b>				22c. DATE SIGNED <b>10/15/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/6/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mable Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Aurora, Mo.</b>					
24. FUNERAL DIRECTOR <b>Arnold Funeral Home; Aurora, Mo.</b>				ADDRESS		25. DATE RECD. BY LOCAL REG. <b>10/5/59</b>		26. REGISTRAR'S SIGNATURE <i>Ora Mc Natt</i>		

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 Irvin R. Arnold

Licensed Embalmer No. 4929

P. O. Address Harold, N

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.