URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–035850

STATE FILE NUMBER

FILED VS NOV 2 1959

Registration District No. 28 Primary Registration District No. 2000 Registrar's No. 1135

1. PLACE OF DEATH
a. COUNTY Green
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Length of stay in 1b: 6 wks
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Burge Hospital — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY Wright
c. CITY OR TOWN Hartville — Inside Limits: Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) N.W. Hartville — Reside on Farm: Yes ☑ No ☐

3. NAME OF DECEASED (Type or print): First John Middle Calvin Last Jones
4. DATE OF DEATH: Month 10 Day 22 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8-27-1897
9. AGE (last birthday): 62
IF UNDER 1 YEAR: Months 1 Days 26 — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARM
11. BIRTHPLACE (City and state or country): WRIGHT Co.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: GEORGE JONES
13b. MOTHER'S MAIDEN NAME: Royster
14. NAME OF HUSBAND OR WIFE: EVA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 500-36-6805
17. INFORMANT: JAKE Cunningham Address: Marshfield Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) C.V.A. — INTERVAL BETWEEN ONSET AND DEATH: 2 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Bronchopneumonia — 1 month
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 9/12/59 to 10/22/59 and last saw her/him alive on 10/22/59
Death occurred at 2:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Thos. E. Cochran (Degree or title) MD
22b. ADDRESS Springfield Mo
22c. DATE SIGNED 10/27/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10/25/59
23c. NAME OF CEMETERY OR CREMATORY Steele Cem.
23d. LOCATION (City, town, or county) Wright Co. Mo. (State)

24. FUNERAL DIRECTOR JOHN S. Simpson ADDRESS Hartville Mo
25. DATE RECD. BY LOCAL REG. 10-27-59
26. REGISTRAR'S SIGNATURE Effie G. Melton

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Warren C. Simpson

Signature of Student Embalmer

Licensed Embalmer No. 507/

P. O. Address_____

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