

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036025

FILED VS NOV 9 1959

STATE FILE NUMBER

Registration District No. 41 Primary Registration District No. 3025 Registrar's No. 145

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		Length of stay in 1b) <u>40 hrs</u>	c. CITY OR TOWN <u>West Plains Mo</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>705 Seven</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Howard</u> Last <u>Jones</u>			4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>59</u>	
--	--	--	--	--

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/14/26</u>	9. AGE (last birthday) <u>32</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
-----------------	---------------------------	---	-------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Driver</u>	10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <u>Melbourne, Ark</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	--	---	---

13a. FATHER'S NAME <u>Hubert Jones</u>	13b. MOTHER'S MAIDEN NAME <u>Lydia Kough</u>	14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <u>Yes</u>	16. SOCIAL SECURITY NO. <u>W. Jones, West Plains Mo</u>	17. INFORMANT <u>W. Jones, West Plains 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>Traumatic Shock</u>	<u>43 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chest Contusion</u>	<u>43 hrs</u>
	DUE TO (c) <u>Auto Accident</u>	<u>43 hrs</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Multiple Contusions &amp; Abrasions</u>	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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	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.) <u>046</u>	20f. CITY, TOWN, OR LOCATION <u>046</u>	COUNTY	STATE
--	--	--	--------	-------

21. I attended the deceased from 10-17 to 59 and last saw her/him alive on 10-19-59  
Death occurred at 3:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <u>W. Jones</u>	22b. ADDRESS <u>West Plains Mo</u>	22c. DATE SIGNED <u>10/19/59</u>
---	---------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>10/22/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	23d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>
---	------------------------------	---	--

24. FUNERAL DIRECTOR <u>Koberline West Plains Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-4-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*D. A. Roberts*

Licensed Embalmer No. 2437

P. O. Address Levent H.

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