

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 4 1959

59-036783

STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 116

ENDED

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u>		Length of stay in 1b <u>47 days</u>	c. CITY OR TOWN <u>Gideon</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>Missouri State Sanatorium</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Taylor</u> Middle _____ Last <u>Jones</u>			4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>Male</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>8-12-1900</u>	9. AGE (last birthday) <u>59</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>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Kentucky</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Perry Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Annie Wallace</u>		14. NAME OF HUSBAND OR WIFE	
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>407-01-5967</u>	17. INFORMANT <u>San.records, Mo. State San., Mt. Vernon, 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 Pulmonary tuberculosis far advanced, active</u>					INTERVAL BETWEEN ONSET AND DEATH <u>?</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 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. 20, 1959</u> , to <u>Oct. 6, 1959</u> and last saw <u>xxx</u> him live on <u>10-6-59</u> Death occurred at <u>8:30 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>George H. Fossett, M.D.</u>			22b. ADDRESS <u>Mt. Vernon, Missouri</u>		22c. DATE SIGNED <u>10-12-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-6-59</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) <u>Gideon</u>	(State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>H. D. Fossett, Mt. Vernon, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>10-12-59</u>	26. REGISTRAR'S SIGNATURE <u>Cecil Hendricks</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6581 WADN SA

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 W.E., Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed H.W. Fennell

Licensed Embalmer No. 2201

P. O. Address Mt. Vernon,

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.