

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040966

STATE FILE NUMBER

FILED VS DEC 8 1959 209

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 373

1. PLACE OF DEATH a. COUNTY MARION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY PIKE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HANNIBAL		Length of stay in 1b 9 days	c. CITY OR TOWN FRANKFORD
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. ELIZABETH HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First SARAH Middle KATHERINE Last JONES			4. DATE OF DEATH Month Nov Day 26 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JUNE 9 1871	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) PIKE Co. MISSOURI	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME CURTIS WILBURN MARTIN		13b. MOTHER'S MAIDEN NAME MARY HUME	14. NAME OF HUSBAND OR WIFE ROBERT JONES			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT Address DONALD JONES 517 S. 12th ST Ponca City OKLA.
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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) Terminal bronchial pneumonia		2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic heart disease	unknown
	DUE TO (c) Auricular fibrillation	

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
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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 11/12/59 to 11/26/59 and last saw her/him alive on 11/25/59
 'Death occurred on 2/12/59 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Edith M. Jones</i> M.D.	22b. ADDRESS 100 N. 6th, Hannibal, Missouri	22c. DATE SIGNED 11/27/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Nov. 28-1959	23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEM	23d. LOCATION (City, town, or county) (State) FRANKFORD Mo.
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24. FUNERAL DIRECTOR ADDRESS MEGOWN FUNERAL HOME, FRANKFORD Mo	25. DATE RECD. BY LOCAL REG. 11/27/59	26. REGISTRAR'S SIGNATURE <i>E. M. Jones</i>
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(Licensed Embalmer's Statement on Reverse Side)

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 Jane Fields Meyers

Licensed Embalmer No. 4093

P. O. Address Frankford

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.