

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JAN - 5 1960

'59 044552

STATE FILE NUMBER

Registration District No. 63 Primary Registration District No. 3031 Registrar's No. 93

ENDED

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>DE SOTO</u> Length of stay in 1b <u>YRS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>JEFF</u> c. CITY OR TOWN <u>DE SOTO</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1705 N. 4th ST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1705 N. 4th ST</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1705 N. 4th ST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>WILARD</u> Last <u>JONES</u>	4. DATE OF DEATH Month <u>DEC</u> Day <u>27</u> Year <u>1959</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-1886</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	11. BIRTHPLACE (City and state or country) <u>FREIDRICKTOWN, MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JOSEPH JONES</u>	13b. MOTHER'S MAIDEN NAME <u>EVELYN DIAMOND</u>	14. NAME OF HUSBAND OR WIFE <u>GRACE JONES</u>
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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>498-09-6460</u>	17. INFORMANT <u>GRACE JONES</u> Address <u>1705 N. 4th DE SOTO, MO</u>
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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: IMMEDIATE CAUSE (a) <u>Emphysema - Ch.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs</u>
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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 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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____
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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
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21. I attended the deceased from 10-3-59 to Dec 27-59 and last saw him alive on 12-26-59
 Death occurred at 12-27-59 9:30 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Charles E. Fallis M.D.</u>	22b. ADDRESS <u>De Soto Mo</u>	22c. DATE SIGNED <u>12-28-59</u>
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23a. BURIAL, CREMATION, REMOVAL, etc. (Specify) <u>Burial</u>	23b. DATE <u>12/29/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>	23d. LOCATION (City, town, or county) (State) <u>DE SOTO MO</u>
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24. FUNERAL DIRECTOR ADDRESS <u>MAHN FUNERAL HOME De Soto Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 28-1959</u>	26. REGISTRAR'S SIGNATURE <u>Marie Harris</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN

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 Gerald J. Mah...

Licensed Embalmer No. 4975

P. O. Address De Soto, M...

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.