RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-010574
STATE FILE NUMBER

FILED VS MAR 28 1960

IDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 333

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Greene
c. CITY OR TOWN: Springfield
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 723 E. Elm
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: KYRON Middle: Last: JONES

4. DATE OF DEATH: Month: March Day: 17 Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 19 Oct. 1908

9. AGE (last birthday): 51

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HR: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern Operator

10b. KIND OF BUSINESS OR INDUSTRY: Tavern

11. BIRTHPLACE (City and state or country): Missouri

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Calmo Jones

13b. MOTHER'S MAIDEN NAME: Martha Youngblood

14. NAME OF HUSBAND OR WIFE: Ethel Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 491-05-1531

17. INFORMANT Address: Ethel Jones (Wife) 723 E. Elm Springfield, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Aneurysm, rt. internal carotid artery — 3 wks.
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

MEDICAL CERTIFICATION

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 2/16/60, to 3/17/60 and last saw him/her alive on 3/17/60

Death occurred at 5:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. McAlhany, MD

22b. ADDRESS: 609 Cherry Springfield, Missouri

22c. DATE SIGNED: 3/21/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3-21-60

23c. NAME OF CEMETERY OR CREMATORY: White Chapel Cemetery

23d. LOCATION (City, town, or county) (State): Springfield, Missouri

24. FUNERAL DIRECTOR: Klingner Mortuary ADDRESS: Springfield, Mo.

25. DATE RECD. BY LOCAL REG.: 3-23-60

26. REGISTRAR'S SIGNATURE: Effie L. Mellon

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

FEB 28 1967

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 407

P. O. Address _____

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