

MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-014015

FILED VS APR 8 1960 378

6286

16

STATE FILE NUMBER

| | | | | | |
|---|--|---|---|--|---------------------------------|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY <u>Wright</u> | | a. STATE <u>Missouri</u> | | b. COUNTY <u>Wright</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wood (Twp)</u> | | Length of stay in lb <u>Life</u> | | c. CITY OR TOWN <u>Mtn. Grove</u> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>P. F. D. # 3</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>P. F. D. # 3</u> | |
| 3. NAME OF DECEASED (Type or print) | | First <u>Francis</u> | | Last <u>Louise Cones</u> | |
| 4. DATE OF DEATH | | Month <u>March</u> Day <u>7</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</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>6/6/1866</u> | | 9. AGE (last birthday) <u>93</u> | | 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) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Franklin County, Mo - U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Albert Jackson Arnall</u> | | 13b. MOTHER'S MAIDEN NAME <u>Charlotte Temple</u> | | 14. NAME OF HUSBAND OR WIFE <u>Wm. M. Cones</u> | |
| 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. | | 17. INFORMANT <u>Alfred Hausley - Mtn. Grove, 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>Carcinoma, Spleen</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Not Specified</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <u>Arteriosclerosis</u> | | <u>Mar. Kneubey</u> | |
| 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 Month, Day, Year a.m. p.m. | | | | | |
| 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>3-20-59</u> to <u>3-21-60</u> and last saw her/him alive on <u>3-6-60</u> | | | | | |
| Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>S. C. Cooper M.D.</u> | | | 22b. ADDRESS <u>W. Mountain Road Mtn. Grove, Mo</u> | | 22c. DATE SIGNED <u>3-22-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>3/10/1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Thomas Cemetery Wright County, Mo</u> | |
| 23d. LOCATION (City, town, or county) (State) | | 23e. DATE RECD. BY LOCAL REG. <u>3-22-1960</u> | | 23f. REGISTRAR'S SIGNATURE <u>Bernice R. Silverman</u> | |
| 24. FUNERAL DIRECTOR <u>Barber Funerals Home - Mtn. Grove, Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>3-22-1960</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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

George Staff

Licensed Embalmer No. 5161
P. O. Address 1111 Brown

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