

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-022484**

FILED VS JUL 12 1960

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 192

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton, Missouri</u>			Length of stay in 1b <u>3 yrs</u>		c. CITY OR TOWN <u>Novinger</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route 2</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Carl</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1960</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 type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10/23/03</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR 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>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Novinger, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William D. Jones</u>			13b. MOTHER'S MAIDEN NAME <u>Maggie Snyder</u>		14. NAME OF HUSBAND OR WIFE <u>unk.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk.</u>			16. SOCIAL SECURITY NO. <u>unk.</u>	17. INFORMANT Address <u>State Hospital No. 1, Fulton, Mo. (records</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>Epidermoid carcinoma of the base of the tongue</u> DUE TO (b) <u>with extension to pterygoid space, and</u> DUE TO (c) <u>cervical metastases.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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							INTERVAL BETWEEN ONSET AND DEATH
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. <input checked="" type="checkbox"/> attended the deceased from <u>State Hospital No. 1</u> <u>12/12/57</u> to <u>7/7/60</u> and last saw her/him alive on <u>XXXXXXXX. XX</u> Death occurred at <u>5:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>James K. Oltleisner, M.D.</u>			22b. ADDRESS <u>State Hospital No. 1, Fulton, Mo.</u>			22c. DATE SIGNED <u>7/7/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-9-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RINGO POINT CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ADAIR COUNTY Mo.</u>			
24. FUNERAL DIRECTOR <u>Morgan Funeral Home</u>		ADDRESS <u>Fulton Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>July-9-1960</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</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 J. W. Rossow  
Licensed Embalmer No. 9555

P. O. Address Fullon

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.