URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUN 22 1960

-60-023578
STATE FILE NUMBER

ENDED

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 302

1. PLACE OF DEATH
a. COUNTY JASPER
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JOPLIN — Length of stay in 1b YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JASPER
c. CITY OR TOWN JOPLIN — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 324 ST. CHARLES AVE. (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First BERT Middle HENRY Last JONES
4. DATE OF DEATH Month JUNE Day 8, Year 1960
5. SEX M
6. COLOR OR RACE W
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH 2-7-1893
9. AGE (last birthday) 67 — 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) RETIRED TEAMSTER
10b. KIND OF BUSINESS OR INDUSTRY HAULING
11. BIRTHPLACE (City and state or country) MT. VERNON, MO.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME ALLEN JONES
13b. MOTHER'S MAIDEN NAME CORNELIA JONES
14. NAME OF HUSBAND OR WIFE LENA JONES, DEC'D 2-21-1943
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. UNK
17. INFORMANT HENRY F. JONES, 324 ST. CHARLES AVE. JOPLIN, MO. Address

MEDICAL CERTIFICATION

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)	Strangulation due to aspiration of bloody vomitus.	5 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Uremia	About 5 days
DUE TO (c)	Bilateral pyelonephritis septicemia	Over 3 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Salmonella infection (not typhoid)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 5-23-60, to 6-8-60 and last saw ~~her~~ him alive on 6-7-60
Death occurred at 6:00 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE B. E. DeTar, Jr. M.D. (Degree or title) B.E. DeTar Jr. M.D.
22b. ADDRESS DeTar Clinic 410 Jackson, Joplin, Mo.
22c. DATE SIGNED 6-11-60

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 6-11-60
23c. NAME OF CEMETERY OR CREMATORY FOREST PARK CEMETERY,
23d. LOCATION (City, town, or county) JOPLIN, MISSOURI (State)

24. FUNERAL DIRECTOR STEVE PARKER MORTUARY, JOPLIN, MO. ADDRESS
25. DATE RECD. BY LOCAL REG. 6-15-1960
26. REGISTRAR'S SIGNATURE Dorce Murriam

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT 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 F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin Mo

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 sb stated above.