

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 21 1960

-60-025586

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 121 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Vernon			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township		Length of stay in 1b 2yrs. 10 mo.	c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION State Hosp. # 3		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 100 East Locust		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Nellie Middle H. Last Jones			4. DATE OF DEATH Month June Day 14 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-23-92	9. AGE (last birthday) 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (City and state or country) Greene County, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Solomon Fields		13b. MOTHER'S MAIDEN NAME Effie Stubblefield		14. NAME OF HUSBAND OR WIFE Ira M. Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Records of State Hospital # 3, Nevada, 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) Coronary Vessel Disease					INTERVAL BETWEEN ONSET AND DEATH Years
DUE TO (b) Atheromatous Sclerosis					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CBS with Cerebral Arteriosclerosis with Psychotic Reaction.					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ 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. I attended the deceased from 8-22-1957 to 6-14-1960 and last saw her ^{her} ₁₉₆₀ alive on 6-14-60 Death occurred at 12:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22. SIGNATURE (Degree or title) <i>E. Allen Pickens, M.D.</i> E. Allen Pickens, M.D.			22b. ADDRESS State Hosp. # 3, Nevada, Mo.		22c. DATE SIGNED 6-14-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/14/60	23c. NAME OF CEMETERY OR CREMATORY Green Lawn		23d. LOCATION (City, town, or county) (State) Springfield, Missouri	
24. FUNERAL DIRECTOR ADDRESS H. Loymeyer, Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 6-15-1960	26. REGISTRAR'S SIGNATURE <i>Anna E. Perry</i>		

DOCUMENT

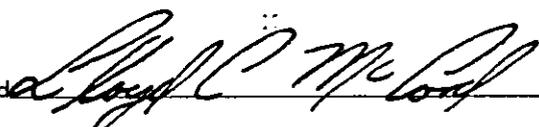
MEDICAL CERTIFICATION

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  _____

Licensed Embalmer No. 4853

P. O. Address Florida, 7

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.