

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 13 1960

=60-030112

STATE FILE NUMBER

Registration District No. 107 107 Primary Registration District No. 3019 Registrar's No. 177

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dunklin</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett</u>		Length of stay in 1b <u>25 Years</u>		c. CITY OR TOWN <u>Kennett</u>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>918 North Vandeventer</u>			Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. STREET ADDRESS (If outside, give location) <u>918 North Vandeventer</u>			Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>_____</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>9th</u> Day <u>2-</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7-2-1885</u>	9. AGE (last birthday) <u>72</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>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Arlington Tenn</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Samuel Jones</u>			13b. MOTHER'S MAIDEN NAME <u>Mary (Unknown)</u>			14. NAME OF HUSBAND OR WIFE <u>Gussie Griffin Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes War I</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Gussie Griffin Jones Kennett 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 Of Colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 Mo.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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"/> N. <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 <u>Aug. 26- 1960</u> to <u>Sept. 2-1960</u> and last saw him alive on <u>Sept. 2nd- 1960</u> Death occurred at <u>8.30 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
21. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>Kennett Mo.</u>			22c. DATE SIGNED <u>9-6-1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-6- 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jonesboro Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Jonesboro Ark.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>T.J. Smith Funeral Home Hayti Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-7-1960</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 2 1968

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 Jack Kelly

Licensed Embalmer No. 3788

P. O. Address Carrollton

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.