

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031194

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STATE FILE NUMBER

Registration District No. 4275 Primary Registration District No. 80 Registrar's No. 80

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Lawrence</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marionville</u> Length of stay in 1b <u>17 mos.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Methodist Home for the Aged</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Jasper</u> c. CITY OR TOWN <u>Carthage</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1810 St. Garrison</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>CLARA</u> Middle <u>ESELLA</u> Last <u>JONES</u>			<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>30</u> Year <u>1960</u>				
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-1-1874</u>	<b>9. AGE</b> (last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>domestic</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>at home</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Kingston, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA.</u>	
<b>13a. FATHER'S NAME</b> <u>John W. Armstrong</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Attie Shumway</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Marcellus W. Jones</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>John W. Jones, 1810 Garrison Carthage, Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Ascending Colon.</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"/> No <input type="checkbox"/> Unknown					<b>18b. INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 year</u>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____ <b>STATE</b> _____			
<b>21. I attended the deceased from</b> <u>Sept 15, 1959</u> <b>and last saw her</b> <u>Aug 29, 1960</u> <b>alive</b> <u>August 29, 1960</u> Death occurred at <u>8:30 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Samuel L. Selvey M.D.</u>			<b>22b. ADDRESS</b> <u>Aurora, Mo</u>		<b>22c. DATE SIGNED</b> <u>8-30-60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>		<b>23b. DATE</b> <u>9-2-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Newcomers Crematory</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Kansas City, Mo</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>KNELL MORTUARY Carthage, Mo</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>8-30-60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Ora Mc Natt</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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert H. Knell

Licensed Embalmer No. 445  
P. O. Address Carthage

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