

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 26 1960

-60-034431

Registration District No. 128 Primary Registration District No. 2002 Registrar's No. 953 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Greene</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b	c. CITY OR TOWN <u>Springfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route #3, Box 1042</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>H.</u> Last <u>Jones</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</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>2-14-1889</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stone</u>	11. BIRTHPLACE (City and state or country) <u>Sebanon, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>Herbert Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Martha</u>		14. NAME OF HUSBAND OR WIFE <u>Lucy Jones</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>    </u>	17. INFORMANT Address <u>Mrs. Lucy Jones, Springfield, 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>Cardiac arrest</u>					INTERVAL BETWEEN ONSET AND DEATH <u>    </u>	
DUE TO (b) <u>Coronary thrombosis with</u>					<u>2 wks</u>	
DUE TO (c) <u>posterior septal myocardial infarct</u>					<u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Massive hemorrhage from gastric ulcer</u>					PART III. I deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 <u>    </u> Month, Day, Year a.m. <u>    </u> p.m. <u>    </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>Sept 13, 1960</u> to <u>only</u> and last saw <sup>her</sup> him alive on <u>    </u> Death occurred at <u>7:29 h.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>William W. Wood MD</u> (Degree or title)			22b. ADDRESS <u>Springfield, Mo.</u>		22c. DATE SIGNED <u>9/16/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-16-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sebanon Cemetery</u>	23d. LOCATION (City, town, or county) <u>Sebanon, Missouri</u>			
24. FUNERAL DIRECTOR <u>Ree Rainey, Springfield, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-19-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</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 Lee Maxon

Licensed Embalmer No. 4568  
P. O. Address Beulah

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.