

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 2 1 1960

=60-042741

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 208 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>	Length of stay in 1b <u>4 2 Months</u>	c. CITY OR TOWN <u>Braymer RFD</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>Millers Rest Home</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Grape Grove Twn</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>HENRY</u> Last <u>JONES</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>9th</u> Year <u>1960</u>	
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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>6-19-1875</u>	9. AGE (last birthday) <u>88yrs</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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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>retired</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>William H. Jones</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah J. Silkwood</u>	14. NAME OF HUSBAND OR WIFE <u>Mary Emma Jones</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Lena Hughes, Carrollton, Mo</u>
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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>Hypostatic Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>36 hr.</u> <u>2-3 yr.</u>
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

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.)
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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 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
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21. I attended the deceased from 4-5-57 to 11-9-60 and last saw ^{her}him alive on 11-9-60
Death occurred at 7:55 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>R.W. Matney MD.</u>	22b. ADDRESS <u>Chillicothe, Mo</u>	22c. DATE SIGNED <u>11-11-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-12-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tinney's Grove Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Braymer, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Mead-Pitts Funeral Service, Braymer, Mo</u> <u>B.F.M.</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 11, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 *Bernard J. Mead*

Licensed Embalmer No. 2801

P. O. Address Braymer, Mo

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.