RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JAN 2 1961

-60-048530
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 253

1. PLACE OF DEATH
a. COUNTY VERNON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON TOWNSHIP | Length of stay in 1b 5Y-9M-18D
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION STATE HOSP. #3, NEVADA, MO | Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY BARTON CO.
c. CITY OR TOWN MILFORD, MO BOX 1 | Inside Limits Yes ☒ No ☐
d. STREET ADDRESS — (If outside, give location) | Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First SALLY Middle ROSE Last JONES

4. DATE OF DEATH Month DEC. Day 23 Year 1960

5. SEX F
6. COLOR OR RACE W
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH AUG. 6. 1896
9. AGE (last birthday) 64 YRS
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) HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (City and state or country) PARNELL MISSOURI
12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME VANDEL AUTEN
13b. MOTHER'S MAIDEN NAME RACHEL ?
14. NAME OF HUSBAND OR WIFE JOHN D. JONES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT HOSP. RECORDS Address NEVADA STATE HOSP. #3 MO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	BRONCHO PNEUMONIA	2 WEEKS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	PULMONARY TB	2 YEARS
DUE TO (c)	—	—

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
GENERALIZED ART. SCLEROSIS - YEARS

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 3-7-53, to 12-23-60 and last saw her/him alive on 12-23-60
Death occurred at 9:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Geo. Esther M.D. (Degree or title)
22b. ADDRESS STATE HOSP. #3, NEVADA, MO
22c. DATE SIGNED 12-23-60

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 12-26-1960
23c. NAME OF CEMETERY OR CREMATORY local
23d. LOCATION (City, town, or county) (State) Maryville, Missouri

24. FUNERAL DIRECTOR ADDRESS Price Funeral Home, Maryville, Missouri
25. DATE RECD. BY LOCAL REG. Dec. 29-1960
26. REGISTRAR'S SIGNATURE Anna E. Ferry

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF

DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed L Douglas Ferry

Signature of Student Embalmer

Licensed Embalmer No. 496

P. O. Address Nevada,

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.