

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004365

FILED VS JAN 10 1967

354

4579

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Texas</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Texas</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cabool</b>			Length of stay in 1b <b>2 wks.</b>		c. CITY OR TOWN <b>Cabool</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Main Street</b>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Main St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Jimmie</b> Middle <b>Scott</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>6,</b> Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-23-60</b>	9. AGE (last birthday) <b>2 weeks</b>	IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b>	IF UNDER 24 HR Hours <b>14</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and state or country) <b>Cabool, Mo.</b>		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME <b>Jimmie J. Jones</b>			13b. MOTHER'S MAIDEN NAME <b>Rita Kathryn Edwards</b>			14. NAME OF HUSBAND OR WIFE <b>none</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Jimmie J. Jones, Cabool, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrocephalus</b> DUE TO (b) <b>Congenital abnormalities</b> DUE TO (c) <b>meningococcal left Clubfoot Spina bifida</b>							INTERVAL BETWEEN ONSET AND DEATH <b>congenital</b>
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 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 <b>12/23/60</b> to <b>1/6/61</b> and last saw <del>him</del> <b>her</b> alive on <b>1/6/61</b> Death occurred at <b>6:30</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>J. L. Spears M.D.</b> (Degree or title)				22b. ADDRESS <b>Cabool, Mo.</b>			22c. DATE SIGNED <b>1/7/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>1-8-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Thayer City Cemetery</b>		23d. LOCATION (City, town, or county) <b>Thayer, Missouri</b>		(State)
24. FUNERAL DIRECTOR <b>Elliott-Gentry, Cabool, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>1-7-61</b>		REGISTRAR'S SIGNATURE <b>Gaynell Cunningham</b>	

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed No Embalming

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.