

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-005880

FILED VS MAR 9 1961 200

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 39

STATE FILE NUMBER

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>MACON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> , COUNTY <u>MACON</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RUSSEL</u>		Length of stay in 1b <u>59 YRS</u>		c. CITY OR TOWN <u>NEW CAMBRIA</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>HOME</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2 1/2 MILES NORTH</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>VELLA</u> Middle <u>MAY</u> Last <u>JONES</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>3</u> Year <u>1961</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>8/25/1897</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u>	IF UNDER 24 HR Hours <u>9</u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (City and state or country) <u>ETHEL MACON MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>JOHN LOUIS WILLIAMS</u>			13b. MOTHER'S MAIDEN NAME <u>JOAN ST. CLAIR</u>			14. NAME OF HUSBAND OR WIFE <u>RICHARD ALBERT 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>			16. SOCIAL SECURITY NO. <u>MO</u>		17. INFORMANT <u>Richard H Jones New Cambria Mo.</u>				
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) <u>Uremia</u>							<u>1 week</u>		
DUE TO (b) <u>Advanced arteriosclerotic nephrosclerosis</u>							<u>4 months</u>		
DUE TO (c) <u>Arteriosclerosis</u>							<u>years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)					
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 <u>July 1960</u> to <u>March 1961</u> and last saw her alive on <u>March 2 1961</u> Death occurred at <u>3:15 PM</u> <u>March 3, 1961</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Louis W. Brittenburg Jr. D.D.</u>				22b. ADDRESS <u>Macon, Missouri</u>			22c. DATE SIGNED <u>3-4-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MARCH 5, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW CAMBRIA CEMETERY</u>			23d. LOCATION (City, town, or county) (State) <u>NEW CAMBRIA Mo.</u>			
24. FUNERAL DIRECTOR <u>H. G. Hillard</u>			ADDRESS <u>New Cambria MO</u>		25. DATE RECD. BY LOCAL REG. <u>March 7, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Cliff M. Sweeney</u>		

**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 H. G. Gilliland

Licensed Embalmer No. 4019

P. O. Address New Cambria 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.