MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-014721
STATE FILE NUMBER

AMENDED

Registration District No. 278 Primary Registration District No. 3454 Registrar's No. 46

FILED APR 26 1961

1. PLACE OF DEATH
a. COUNTY: PIKE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: FRANKFORD
Length of stay in 1b: 7 YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: PIKE
c. CITY OR TOWN: FRANKFORD
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First LURA Middle DEAN Last JONES

4. DATE OF DEATH: Month APRIL Day 16 Year 1961

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: JUNE 24 1881
9. AGE (last birthday): 79
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): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): FRANKFORD Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: JOHN FARRELL
13b. MOTHER'S MAIDEN NAME: SARAH PRITCHETT
14. NAME OF HUSBAND OR WIFE: HOMER 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: HOMER JONES Address: FRANKFORD Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cardiac Asthma
DUE TO (c) Hypertension
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ Yes ☐ No ☐ Unknown

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 1945, to 1961 and last saw her/him alive on Apr. 16, 61
Death occurred at 3:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): E. P. Hansen DO.
22b. ADDRESS: Frankford
22c. DATE SIGNED: 4-17-61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: APRIL 18-1961
23c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEMETERY
23d. LOCATION (City, town, or county) (State): FRANKFORD Mo.

24. FUNERAL DIRECTOR: MEGOWN FUNERAL HOME ADDRESS: FRANKFORD Mo
25. DATE RECD. BY LOCAL REG.: Apr 19-61
26. REGISTRAR'S SIGNATURE: Bernice Collier

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. SHOULD READ INSTEAD OF DATE AMENDED
BY AFFIDAVIT OF DOCUMENT

APR 27 1961

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 Lone Fields Megown

Licensed Embalmer No. 4093

P. O. Address Frankford Me

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.