SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-024806
STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 641B

FILED JUL 17 1961

DATE AMENDED

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield
Length of stay in 1b: 18 days
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Johns Hospital
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Missouri
b. COUNTY Laclede
c. CITY OR TOWN Lebanon
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 352 Clark St.
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Roy Middle: Last: Jones

4. DATE OF DEATH Month: July Day: 3 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: Nov. 28 1895
9. AGE (last birthday): 65
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): Auto Mechanic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Orla, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Grant Jones
13b. MOTHER'S MAIDEN NAME: Julia Adams
14. NAME OF HUSBAND OR WIFE: Chloda B. Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service: yes World War I
16. SOCIAL SECURITY NO.
17. INFORMANT: Freda Stange Address: Elsmore Kan.

INSTEAD OF

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the larynx — INTERVAL BETWEEN ONSET AND DEATH: Several mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) with metastases
DUE TO (c)
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

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 July 1 1961 to July 3 1961 and last saw her/him alive on July 3, 1961
Death occurred at 5:20 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W. Yates Trotter, MD
22b. ADDRESS Professional Bldg Springfield Mo.
22c. DATE SIGNED 7-9-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 7/5/1961
23c. NAME OF CEMETERY OR CREMATORY City Cemetery
23d. LOCATION (City, town, or county) Lebanon (State) Mo.

24. FUNERAL DIRECTOR Dorsey M. Howe ADDRESS Lebanon, Mo.
25. DATE RECD BY LOCAL REG. 7-10-61
26. REGISTRAR'S SIGNATURE Effie J. Melton

(Licensed Embalmer's Statement on Reverse Side)

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

ITEM NO.

JUL 17 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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon

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.