

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025947

AMENDED

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 118 STATE FILE NUMBER 61-025947

FILED JUL 19 1961

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>Macon</u>		Length of stay in lb <u>16 weeks</u>	c. CITY OR TOWN <u>New Cambria</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Samaritan hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>-----</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cora Reed Jones</u>			4. DATE OF DEATH Month Day Year <u>July 9 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>5/5/90</u>	9. AGE (last birthday) <u>71 yrs.</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>4</u> Hours <u>    </u> Min. <u>    </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and state or country) <u>Bevier, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>John Reed</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Thomas</u>		14. NAME OF HUSBAND OR WIFE <u>David R. 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>-----</u>	17. INFORMANT Address <u>David R. 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: IMMEDIATE CAUSE (a) <u>Terminal Uremia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis Thromboses with Corne</u>				<u>16 wks</u>	
	DUE TO (c) <u>Arteriosclerosis</u>					
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 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 Month, Day, Year a.m. p.m.						
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>April 1961</u> to <u>July 9, 1961</u> and last saw her alive on <u>July 9, 1961</u> Death occurred at <u>7:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>James E. Campbell M.D.</u>			22b. ADDRESS <u>Macon, Mo</u>		22c. DATE SIGNED <u>7/12/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 12, 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 ADDRESS <u>H.F. Killeland New Cambria Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7/12/61</u>	26. REGISTRAR'S SIGNATURE <u>Carl M. Neely.</u>			

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

AUG 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 Howard J. Gilleland

Licensed Embalmer No. 4019

P. O. Address New Canaan, Ma

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.