

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026196

STATE FILE NUMBER

AMENDED

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 228

FILED JUL 24 1961

1. PLACE OF DEATH a. COUNTY <u>PETTIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>MORGAN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SEDALIA</u>		Length of stay in 1b <u>6 DAYS</u>	c. CITY OR TOWN <u>RURAL RICHLAND TWP</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>BOTHWELL HOSP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>10 MILES N.E. STOVER</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTIE JANE JONES</u>			4. DATE OF DEATH Month Day Year <u>JULY 17 1961</u>		
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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>APR 30 1872</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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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>FARM</u>	11. BIRTHPLACE (City and state or country) <u>MORGAN COUNTY Mo. U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME <u>PETER SILVEY</u>	13b. MOTHER'S MAIDEN NAME <u>SARAH RITCHIE</u>	14. NAME OF HUSBAND OR WIFE <u>MART JONES</u>
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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>NONE</u>	17. INFORMANT Address <u>MART JONES VERSAILLES Mo</u>
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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>Bilateral Bronchopneumonia</u>	DUE TO (b) <u>Generalized Atherosclerosis</u>	<u>6 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	<u>years</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
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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.)
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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
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21. I attended the deceased from <u>1955</u> to <u>July 17, 1961</u> and last saw <u>her</u> alive on <u>July 15, 1961</u>

Death occurred at <u>7-17-61 8:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ray Tate, M.D.</u> (Degree or title)	22b. ADDRESS <u>Versailles, Mo.</u>	22c. DATE SIGNED <u>7-19-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>July 19 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VERSAILLES CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>VERSAILLES Mo.</u>
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24. FUNERAL DIRECTOR <u>Schoner-Steamer Stover Mo</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>7-19-1961</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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

J. L. Stevenson

Licensed Embalmer No.

4073

P. O. Address

Stover 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.