

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028798

AMENDED

Registration District No. 100 Primary Registration District No. \_\_\_\_\_ Registrar's No. 93 STATE FILE NUMBER \_\_\_\_\_

FILED SEP 6 1961

|  |  |   |  |  |   |  |   |
|--|--|---|--|--|---|--|---|
| 1. PLACE OF DEATH  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)        |   |  |   |
| a. COUNTY <u>Dent County</u>   |  |   |  | a. STATE <u>Missouri</u>   |   | b. COUNTY <u>Dent</u>  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Salem, Missouri</u>  |  |   | Length of stay in 1b <u>6 days</u>   |  | c. CITY OR TOWN <u>Salem, Missouri</u>                                  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Jones Nursing Home</u>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><u>Salem, Missouri</u> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)  |  |   |  | 4. DATE OF DEATH   |   |  |   |
| First <u>Grace</u>   |  | Middle <u>Alma</u>  |  | Last <u>Jeffries</u>   |   | Month <u>Sept.</u> Day <u>1</u> Year <u>1961</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>       | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 22, 1866</u>   | 9. AGE (last birthday)<br><u>95</u>  | IF UNDER 1 YEAR<br>Months _____ Days _____                              | IF UNDER 24 HR<br>Hours _____ Min. _____   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Housekeeping</u>  |  | 11. BIRTHPLACE (City and state or country)<br><u>Nunda, New York</u>                         |   | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u>   |   |
| 13a. FATHER'S NAME<br><u>John Jeffries Bowen</u>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Marion E. Bowen</u>                                  |  | 14. NAME OF HUSBAND OR WIFE<br><u>Samuel T. Jeffries</u>                |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service)<br><u>X</u>   |  |   | 16. SOCIAL SECURITY NO.<br><u>X</u>  |  | 17. INFORMANT<br><u>Charles B. Jeffries</u><br>Address _____            |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| IMMEDIATE CAUSE (a) <u>General arteriosclerosis (460.942)</u>  |  |   |  |  |   |  |   |
| DUE TO (b) _____   |  |   |  |  |   |  |   |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input 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<br>Hour _____<br>a.m. _____<br>p.m. _____  |  | Month, Day, Year _____  |  |  |   |  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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>7/8/48</u> to <u>8/28/61</u> and last saw her <sup>him</sup> alive on <u>8/24/61</u><br>Death occurred at <u>6:30 p</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |   |  |   |
| 22a. SIGNATURE <u>Marion E. Bowen</u> (Degree or title)  |  |   |  | 22b. ADDRESS<br><u>Salem, Missouri</u>   |   | 22c. DATE SIGNED<br><u>9/2/61</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE<br><u>9-3-1961</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Grove</u>                             |  | 23d. LOCATION (City, town, or county) (State)<br><u>Salem, Missouri</u> |  |   |
| 24. FUNERAL DIRECTOR<br><u>SPENCER FUNERAL HOME INC. SALEM, Mo.</u><br>ADDRESS _____   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>9/2/61</u>  |   | 26. REGISTRAR'S SIGNATURE<br><u>M. M. Hart, M.D., Lyane</u>  |   |

DATE AMENDED

AMENDMENTS ON THIS REPORT ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.