

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Dr. Turner

Registration District No. 728

Primary Registration District No. 2000

Registrar's No. 863C

-61-032516

STATE FILE NUMBER

AMENDED

FILED OCT 2 1961

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. MISSOURI b. COUNTY OREGON			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 9 DAYS		c. CITY OR TOWN THAYER		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) THAYER	
3. NAME OF DECEASED (Type or print) First Middle Last MINNIE KATHRYN JONES				4. DATE OF DEATH Month Day Year SEPT. 11 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/18/88	9. AGE (last birthday) 72	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) HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) OREGON CO. MO.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME MARION E. PERKINS			13b. MOTHER'S MAIDEN NAME MARY ELIZABETH CHANDLER			14. NAME OF HUSBAND OR WIFE HENDERSON JONES (DEC.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address MRS. ALMA ORR, ALTON, MO.			
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>arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH NOT KNOWN	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. 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 a.m. Month, Day, Year 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>9/2/61</u> to <u>9/11/61</u> and last saw ^{her} him alive on <u>9/11/61</u> Death occurred at <u>9 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Glenn T. Turner, M.D.</u>				22b. ADDRESS <u>609 Cherry Springfield</u>		22c. DATE SIGNED <u>9/27/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9/14/61	23c. NAME OF CEMETERY OR CREMATORY TWO MILE CEMETERY		23d. LOCATION (City, town, or county) (State) THAYER, MISSOURI		
24. FUNERAL DIRECTOR ADDRESS H. H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.				25. DATE RECD. BY LOCAL REG. 9-28-61		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>	

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 *H. L. McCarroll*

Licensed Embalmer No. 2787

P. O. Address *Appl...*

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.