

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036687

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED NOV 13 1961

|   |                              |   |  |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>NEW RY</u>  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>St. Clair</u>  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Clinton Mo.</u>   |                              | c. CITY OR TOWN <u>Appleton City Mo.</u>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Klein Nursing Home</u>  |                              | d. STREET ADDRESS (If outside, give location)   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>JEANNE NELSON JONES</u>  |                              | 4. DATE OF DEATH<br>Month Day Year<br><u>Nov. 5 - 1961</u>  |  |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</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>Apr 10 - 71</u> |
| 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   |  |
| 11a. BIRTHPLACE (City and state or country)<br><u>ST. CLAIR Co Mo.</u>  |                              | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |  |
| 13a. FATHER'S NAME<br><u>Wm Eva Nelson</u>  |                              | 13b. MOTHER'S MAIDEN NAME<br><u>Rebecca Smith</u>   |  |
| 14. NAME OF HUSBAND OR WIFE<br><u>None</u>  |                              | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |
| 16. SOCIAL SECURITY NO.   |                              | 17. INFORMANT<br>Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>  |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 hrs</u>  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Myocardial Insufficiency</u>  |                              | <u>48 hrs</u>   |  |
| DUE TO (c) <u>Coronary artery Insufficiency</u>   |                              | <u>years</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Generalized arteriosclerosis &amp; gangrene of Rt. foot</u> |                              | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>a.m. p.m.   |  |
| 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>Sept 1 - 1961</u> to <u>Nov 5, 1961</u> and last saw her alive on <u>Nov. 4, 1961</u>   |                              | Death occurred at <u>12:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |  |
| 22a. SIGNATURE (Degree or title)<br><u>Clinton L. Glesper D.O.</u>  |                              | 22b. ADDRESS<br><u>Clinton, Mo.</u>   |  |
| 22c. DATE SIGNED<br><u>11/6/61</u>  |                              | 22d. LOCATION (City, town, or county)<br>(State)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                              | 23b. DATE<br><u>11-7-61</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Appleton City</u>  |                              | 23d. LOCATION (City, town, or county)   |  |
| 24. FUNERAL DIRECTOR<br><u>Eckhoff</u>  |                              | 25. DATE RECD. BY LOCAL REG.<br><u>Nov 6, 1961</u>  |  |
| 26. REGISTRAR'S SIGNATURE<br><u>Mildred Biggem</u>  |                              | (Licensed Embalmer's Statement on Reverse Side)   |  |

DATE AMENDED

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 \_\_\_\_\_

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.