

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037570

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 57-61

STATE FILE NUMBER

FILED OCT 23 1961

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|-------------------------------------|--------------------------------|--|------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY LAWRENCE | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY LAWRENCE | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN AURORA | | Length of stay in 1b 9 YEARS | | c. CITY OR TOWN AURORA | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION AURORA HOSPITAL | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 520 HIGHLAND | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First VERN Middle J. Last JONES | | | | 4. DATE OF DEATH Month OCT. Day 11 Year 1961 | | | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 10/13/95 | | 9. AGE (last birthday) 65 | | 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) RET. SHELL PIPE LINE CO | | | | 10b. KIND OF BUSINESS OR INDUSTRY OIL | | 11. BIRTHPLACE (City and state or country) MARSHALL, ILL. | | 12. CITIZEN OF WHAT COUNTRY USA | | | | | |
| 13a. FATHER'S NAME EDMUND JONES | | | | 13b. MOTHER'S MAIDEN NAME RUANNAH THOMPSON | | | | 14. NAME OF HUSBAND OR WIFE SARAH F. JONES | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW1 | | | | 17. INFORMANT SARAH F. JONES: AURORA, MO. | | | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 mins | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary Insufficiency | | | | | | | | 10 days | | | | | |
| DUE TO (c) | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 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>7/10/57</u> to <u>10/11/61</u> and last saw her alive on <u>Oct 11 61</u> Death occurred at <u>2:30 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>[Signature]</i> | | | | | | 22b. ADDRESS <i>[Address]</i> | | | 22c. DATE SIGNED <u>10/14/61</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 10/13/61 | | 23c. NAME OF CEMETERY OR CREMATORY MAPLE PARK CEMETERY | | | 23d. LOCATION (City, town, or county) (State) AURORA, MO. | | | | | | |
| 24. FUNERAL DIRECTOR ARNOLD'S FUNERAL HOME: | | | | ADDRESS AURORA, MO. | | 25. DATE RECD. BY LOCAL REG. <u>Oct 17-1961</u> | | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

OCT 24 1961

1961 8 AON

OCT 24 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 James D. Crafton
Licensed Embalmer No. 4668

P. O. Address Churoa 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.