

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-039991

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 1 Registrar's No. 353

FILED DEC 11 1961

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Benton Township</b>	Length of stay in 1b <b>25 yrs</b>	c. CITY OR TOWN <b>Kirksville</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) <del>HOSPITAL OR INSTITUTION</del> <b>West Missouri St</b>		d. STREET ADDRESS (If outside, give location) <b>West Missouri</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ORION</b> Middle <b>REID</b> Last <b>JONES</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>3</b> Year <b>1961</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/13/87</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Nightwatchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Police</b>		11. BIRTHPLACE (City and state or country) <b>Tracy, Marion, Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>U S</b>	
13a. FATHER'S NAME <b>Amos P. Jones</b>			13b. MOTHER'S MAIDEN NAME <b>Mary A. Reid</b>		14. NAME OF HUSBAND OR WIFE <b>Never Married</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Bertha Garrett, Kirksville, Mo.</b>			

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 <b>18 hours</b>
IMMEDIATE CAUSE (a) <b>Apoplexy</b>	years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension</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 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.)			
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 **1954** to **12-7-61** and last saw him alive on **12-2-61**.  
Death occurred at **6:15 p** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i> (Degree or title)	22b. ADDRESS <b>Kirksville</b>	22c. DATE SIGNED <b>12-6-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/6/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sandridge</b>	23d. LOCATION (City, town, or county) (State) <b>Bussey, Marion, Iowa</b>
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24. FUNERAL DIRECTOR <b>Foster Memorial Home, Kirksville, Mo.</b>	ADDRESS <b>12-5-1961</b>	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF

C. L. MARTIN, D.O.

**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 *Nova E. Foster*  
NOVA E. FOSTER

Licensed Embalmer No. 4742

P. O. Address Kirkville, 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.