

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040734

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1151A

**FILED DEC 4 1961**

|  |   |   |  |
|--|---|---|--|
| <p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY <u>Greene</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Length of stay in 1b <u>4 days</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Protestant</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>   |   | <p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u></p> <p>c. CITY OR TOWN <u>Elkland R. R.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>4 Mi. N. W. of Elkland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> |  |
| <p><b>3. NAME OF DECEASED</b> (Type or print) First Middle Last</p> <p><u>HARVEY L. JONES</u></p>  |   | <p><b>4. DATE OF DEATH</b> Month Day Year</p> <p><u>Nov. 24 1961</u></p>  |  |
| <p><b>5. SEX</b> <u>male</u></p>   | <p><b>6. COLOR OR RACE</b> <u>white</u></p>   | <p><b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br/>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>  | <p><b>8. DATE OF BIRTH</b> <u>Aug. 7, 1887</u></p>                                 |
| <p><b>9. AGE</b> (last birthday) <u>74</u></p>   |   | <p><b>IF UNDER 1 YEAR</b> Months Days Hours Min.</p>  | <p><b>IF UNDER 24 HR</b> Hours Min.</p>  |
| <p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>farming</u></p>   |   | <p><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>general</u></p>  | <p><b>11. BIRTHPLACE</b> (City and state or country) <u>Webster Co., Mo.</u></p>   |
| <p><b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u></p>  |   | <p><b>13a. FATHER'S NAME</b> <u>James Hamilton Jones</u></p>  |  |
| <p><b>13b. MOTHER'S MAIDEN NAME</b> <u>Siyona Jane</u></p>   |   | <p><b>14. NAME OF HUSBAND OR WIFE</b> <u>Alma R. Jones</u></p>  |  |
| <p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)</p>   |   | <p><b>16. SOCIAL SECURITY NO.</b></p>   | <p><b>17. INFORMANT</b> Address <u>Alma R. Jones Elkland, Mo.</u></p>              |
| <p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____</p> <p>DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition (List in Part I) (g) <u>Chronic pulmonary emphysema</u></p> <p>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</p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u></p> |   |   |  |
| <p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>   | <p><b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/></p> | <p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of Item 18.)</p>  |  |
| <p><b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year</p>  |   |   |  |
| <p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></p>  | <p><b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                | <p><b>20f. CITY, TOWN, OR LOCATION</b> <u>Springfield Mo</u></p>  | <p><b>COUNTY</b> <u>Webster Co.</u> <b>STATE</b> <u>Mo.</u></p>                    |
| <p><b>21. I attended the deceased from</b> <u>22 Nov 1961</u> to <u>24 Nov 1961</u> and last saw him alive on <u>24 Nov 1961</u></p> <p>Death occurred at <u>11 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>  |   |   |  |
| <p><b>22a. SIGNATURE</b> (Degree or title) <u>Francis M. Maple MD</u></p>  |   | <p><b>22b. ADDRESS</b> <u>Springfield Mo</u></p>  | <p><b>22c. DATE SIGNED</b> <u>28 Nov 1961</u></p>                                  |
| <p><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u></p>  | <p><b>23b. DATE</b> <u>Nov. 26, 1961</u></p>  | <p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mission Chapel</u></p>  | <p><b>23d. LOCATION</b> (City, town, or county) (State) <u>Webster Co. Mo.</u></p> |
| <p><b>24. FUNERAL DIRECTOR</b> ADDRESS <u>L. B. Jones Buffalo, Mo.</u></p>   |   | <p><b>25. DATE RECD. BY LOCAL REG.</b> <u>11-28-61</u></p>  | <p><b>26. REGISTRAR'S SIGNATURE</b> <u>Effie S. Melton</u></p>                     |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

**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 R. E. Cheatham

Licensed Embalmer No. 3813

P. O. Address Buffalo

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.