

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042124

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 447

AMENDED

FILED NOV 22 1961

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>		Length of stay in 1b <u>2 Days</u>		c. CITY OR TOWN <u>Esther</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>OLA</u> Middle <u>M.</u> Last <u>JONES</u>			4. DATE OF DEATH <u>Nov, 17, 1961</u> Month <u>Nov</u> Day <u>17</u> Year <u>1961</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/1905</u>	9. AGE (last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>L. Lawson</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>James Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>James Jones Esther, Mo.</u> 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) <u>Arterio sclerotic heart disease</u> DUE TO (b) <u>diabetes mellitus</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1-2 years</u> <u>unknown</u>
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 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. Month, Day, Year _____		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>Sept 11, 1961</u> to <u>Nov 17, 1961</u> and last saw ^{her} him <u>alive</u> on <u>Nov 17, 1961</u> Death occurred at <u>3:30 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. L. Foster</u> (Degree or title) <u>MS</u>			22b. ADDRESS <u>Desloge, Mo.</u>		22c. DATE SIGNED <u>11/18/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/20/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Falls Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Francois Co. Mo.</u>	
24. FUNERAL DIRECTOR <u>Murphy L. Sparks</u> ADDRESS <u>Flat River, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 18, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>		

DATE AWARDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 Wingby Sparks
Licensed Embalmer No. 4350
P. O. Address East River, N.Y.

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.