

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

~~61-043283~~  
STATE FILE NUMBER  
**61-043283**

Registration District No. 322 Primary Registration District No. 3071 Registrar's No. 31

AMENDED

**FILED DEC 11 1961**

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Slater</u>		Length of stay in 1b <u>19 Yrs.</u>	c. CITY OR TOWN <u>Slater</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>220 E. Parker</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>220 E. Parker</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JUDITH</u> Middle <u>CATHERINE</u> Last <u>JONES</u>	4. DATE OF DEATH Month <u>Dec.</u> Day <u>3</u> Year <u>1961</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/1875</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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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 <u>None</u>	11. BIRTHPLACE (City and state or country) <u>North Gilliam, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>John Lee Hill</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah E. Ford</u>	14. NAME OF HUSBAND OR WIFE <u>John L. Jones</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mrs. Louise Bossaller Slater, Mo</u>
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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>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>with failure</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>48 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Sensibility.</u>		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.)
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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 _____
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21. I attended the deceased from 1942 to Dec. 3, 1961 and last saw her <sup>him</sup> alive on Dec. 3, 1961  
Death occurred at 1:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>C.A. McBurney md.</u>	22b. ADDRESS <u>Slater, Mo.</u>	22c. DATE SIGNED <u>12/9/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/5/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Slater</u>	23d. LOCATION (City, town, or county) (State) <u>Slater, Missouri.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Haines Funeral Home Slater, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 5-1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Reynold Brane</u>
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(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 Walter J. Haines, Jr.

Licensed Embalmer No. 4557

P. O. Address Slater, N

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.