

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044257

MENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1245 STATE FILE NUMBER

FILED DEC 18 1961

1. PLACE OF DEATH a. COUNTY <p style="text-align: center; font-size: 18pt;"><u>Greene</u></p>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <p style="text-align: center; font-size: 18pt;"><u>Springfield</u></p>		Length of stay in 1b <p style="text-align: center; font-size: 18pt;"><u>1 day</u></p>	c. CITY OR TOWN <p style="text-align: center; font-size: 18pt;"><u>Elkland</u></p>
c. FULL NAME OF HOSPITAL OR INSTITUTION <p style="text-align: center; font-size: 18pt;"><u>Springfield Baptist</u></p>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <p style="text-align: center; font-size: 18pt;"><u>4 Mi. N. W. of Elkland</u></p>

3. NAME OF DECEASED (Type or print) First <u>ALMA</u> Middle <u>R.</u> Last <u>JONES</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>1961</u>			
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>April 15, 1889</u>	9. AGE (last birthday) <u>72</u>	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) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>house work</u>		11. BIRTHPLACE (City and state or country) <u>Dallas Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>

13a. FATHER'S NAME <u>Hezekiah Pettitt</u>		13b. MOTHER'S MAIDEN NAME <u>Manda Stever</u>		14. NAME OF HUSBAND OR WIFE <u>Harvey Jones (dec.)</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.		17. INFORMANT Address <u>Paul Pettitt Elkland, Mo.</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <p style="text-align: center; font-size: 24pt; font-weight: bold;"><u>Right middle cerebral artery thrombosis</u></p>		INTERVAL BETWEEN ONSET AND DEATH <p style="text-align: center; font-size: 24pt; font-weight: bold;"><u>5 days</u></p>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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 _____ 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 <u>Springfield Mo</u>	COUNTY <u>Greene Co. Mo.</u>	STATE
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21. I attended the deceased from 11 Dec '61 to 12 Dec '61 and last saw ^{her} him alive on 12 Dec '61
Death occurred at 12:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deed or 1st) <p style="font-size: 24pt; font-weight: bold;"><u>Francis M. Mable MD</u></p>		22b. ADDRESS <u>Springfield Mo</u>		22c. DATE SIGNED <u>17 Dec 61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Dec. 15, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mission Chapel</u>	23d. LOCATION (City, town, or county) (State) <u>Greene Co. Mo.</u>	
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24. FUNERAL DIRECTOR ADDRESS <u>L. B. Jones Buffalo, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-15-61</u>	26. REGISTRAR'S SIGNATURE <p style="font-size: 24pt; font-weight: bold;"><u>Effie S. Meeter</u></p>	
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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 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.