

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-000663  
STATE FILE NUMBER

AMENDED

Registration District No. 35 Primary Registration District No. 3011 Registrar's No. 10

FILED JAN 22 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>CARRIAGE</u>	a. STATE <u>MISSOURI</u> b. COUNTY <u>CARRIAGE</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CARRIAGE, MO.</u>	Length of stay in 1b <u>—</u>	c. CITY OR TOWN <u>CARRIAGE</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>CARRIAGE COUNTY MEMORIAL HOSPITAL</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>210 GRAND AVE.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last <u>RANDALL DEE JONES</u>		Month Day Year <u>JANUARY 14, 62</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-62</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (last birthday) <u>14-20 MIN.</u>
11. BIRTHPLACE (City and state or country) <u>CARRIAGE, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>GILFORD KENNETH JONES</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH LANCE</u>	
14. NAME OF HUSBAND OR WIFE <u>—</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>GILFORD JONES</u>		Address <u>CARRIAGE, MO.</u>	
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
IMMEDIATE CAUSE (a) <u>CONGENITAL ABNORMALITY OF</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>HEART, LIVER AND SPLEEN</u>			
DUE TO (c) <u>(PATIENT LIVED FOR 80 MIN. AFTER BIRTH)</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 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 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>1-14-62</u> to <u>1-14-62</u> and last saw him alive on <u>1-14-62</u>			
Death occurred at <u>9:20 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Edward H. Smith M.D.</u>		22b. ADDRESS <u>10749 St. Carollton, Mo.</u>	22c. DATE SIGNED <u>1/14/62</u>
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>	23b. DATE <u>1-15-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carroll Memorial Gardens</u>	23d. LOCATION (City, town, or county) (State) <u>Carrollton MO.</u>
24. FUNERAL DIRECTOR <u>Gibson Funeral Home</u>	ADDRESS <u>Carrollton Mo</u>	25. DATE RECD. BY LOCAL REG. <u>1-16-62</u>	26. REGISTRAR'S SIGNATURE <u>Wesley C. Palmer</u>

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 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 James F. Gibson  
Licensed Embalmer No. 5076

P. O. Address Carrollton, 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.