

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-006891

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 36

**FILED MAR 2 1962**

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  |   |
| a. COUNTY<br><b>Jasper</b>  |   | a. STATE <b>Missouri</b> b. COUNTY <b>Jasper</b>   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN<br><b>Carthage</b>   |   | c. CITY OR TOWN<br><b>Carthage</b>   |   |
| Length of stay in 1b<br><b>25 yrs</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>621 E. Vine St.</b>                          |   | d. STREET ADDRESS (If outside, give location)<br><b>621 E. Vine St.</b>  |   |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)   |   |  | 4. DATE OF DEATH  |
| First Middle Last<br><b>ROSETTA E. JONES</b>  |   |  | Month Day Year<br><b>Feb. 17, 1962</b>  |
| 5. SEX  | 6. COLOR OR RACE  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH  |
| <b>female</b>   | <b>white</b>  |  | <b>7-9-1892</b>   |
| 9. AGE (last birthday)  |   | IF UNDER 1 YEAR  | IF UNDER 24 HR  |
| <b>69</b>   |   | Months Days  | Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                       |   | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (City and state or country)  |
| <b>housewife</b>  |   | <b>at home</b>   | <b>Grove, Okla</b>  |
| 12. CITIZEN OF WHAT COUNTRY   |   | <b>USA</b>   |   |
| 13a. FATHER'S NAME  |   | 13b. MOTHER'S MAIDEN NAME  | 14. NAME OF HUSBAND OR WIFE   |
|   |   |  | <b>George W. Jones</b>  |
| 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.  | 17. INFORMANT   |
| <b>no</b>   |   | <b>none</b>  | <b>G. W. Jones, 621 E. Vine, Carthage, Mo</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (a) <b>Presumed natural causes</b>  |   |  |   |
| 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 |
| 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 <b>did not attend</b> and last saw <b>her</b> alive on _____                                     |   | Death occurred at <b>app 12:30 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.  |   |
| 22a. SIGNATURE (Degree or title)<br><b>W. H. Clenton, Local Registrar</b>   |   | 22b. ADDRESS<br><b>1238 Grand, Carthage, Mo.</b>   | 22c. DATE SIGNED<br><b>2-19-62</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  | 23b. DATE<br><b>2-20-62</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Park Cemetery</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Carthage, Mo</b>                      |
| 24. FUNERAL DIRECTOR<br><b>KNELL MORTUARY Carthage, Mo</b>  |   | 25. DATE RECD. BY LOCAL REG.<br><b>2-19-62</b>   | 26. REGISTRAR'S SIGNATURE<br><b>W. H. Clenton</b>   |

DATE AMENDED  
7  
7  
2

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

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 Robert H Knell

Licensed Embalmer No. 4459

P. O. Address Carthage, 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.