

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-015924

STATE FILE NUMBER

Registration District No. 387 Primary Registration District No. 8099 Registrar's No. 83

FILED MAY 7 1962

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Monroe</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		c. CITY OR TOWN <u>Monroe City</u>	
Length of stay in lb <u>82 days</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>Pershing Memorial</u>		d. STREET ADDRESS (If outside, give location) <u>-----</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alonzo Roland Jones</u>			4. DATE OF DEATH Month Day Year <u>April 27, 1962</u>
5. SEX <u>Male</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>4/24/94</u>
9. AGE (last birthday) <u>68 yrs.</u>		IF UNDER 1 YEAR Months <u>---</u> Days <u>3</u> Hours <u>---</u> Min. <u>---</u>	IF UNDER 24 HR Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>telegrapher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (City and state or country) <u>Bevier, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			
13a. FATHER'S NAME <u>Sidney Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jane Matherley</u>	14. NAME OF HUSBAND OR WIFE <u>Lillian Perry 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>---</u>	17. INFORMANT <u>Mary L. Slater, Brookfield, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE-(a) <u>Uremia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
DUE TO (b) <u>Multiple Metastases</u>			
DUE TO (c) <u>Adenocarcinoma of Cecum</u>			<u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cachexia</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.) <u>---</u>	
20c. TIME OF INJURY Hour <u>---</u> a.m. <u>---</u> p.m. <u>---</u>	Month, Day, Year <u>---</u> <u>---</u> <u>---</u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>	20f. CITY, TOWN, OR LOCATION <u>---</u>	COUNTY <u>---</u> STATE <u>---</u>
21. I attended the deceased from <u>Nov. 4, 1961</u> to <u>April 27, 62</u> and last saw her/him alive on <u>4-27-62</u> Death occurred at <u>4:45 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>D. W. Schubert MD</u>		22b. ADDRESS <u>Brookfield Mo</u>	22c. DATE SIGNED <u>4/29/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/29/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Callao, Mo.</u>
24. FUNERAL DIRECTOR <u>H. J. Gilleland New Cambria Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4/29/62</u>	26. REGISTRAR'S SIGNATURE <u>Anna Watson</u>

MAY 11 1962

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 A. E. Gilleland

Licensed Embalmer No. 4019

P. O. Address New Cambria 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.