

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-038619

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 79

FILED SEP 30 1963

VS 300
Rev. 4/59

1 1050

2 1050

3

4 1

5 1

6

7 1

8 0

9 3.31X

10

11

12 1-2

13 20

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>SUTTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SUTTON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MILAN MO</u>		Length of stay in 1b <u>2-WKS</u>	c. CITY OR TOWN <u>MILAN</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SUTTON COUNTY MEMORIAL HOSP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIE NEOMA JONES</u>			4. DATE OF DEATH Month Day Year <u>SEPT 23 1963</u>
5. SEX <u>FR</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-96</u>
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	9. AGE (last birthday) <u>67</u>
13a. FATHER'S NAME <u>JOSEPH MCCONNELL</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH ROACH</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>NO</u>		16. SOCIAL SECURITY NO. <u>9616</u>	14. NAME OF HUSBAND OR WIFE <u>RALPH JONES</u>
17. INFORMANT <u>RALPH JONES MILAN MO</u>			Address
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>Cerebral accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9-13-63</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>hypertension</u>			<u>5 yr -</u>
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 <u>9-13-63</u> to <u>9-23-63</u> and last saw ^{her} alive on <u>9-23-63</u> Death occurred at <u>1:30 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>[Signature]</u>		22b. ADDRESS <u>Milan</u>	22c. DATE SIGNED <u>9-24-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT 26, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT ZION</u>	23d. LOCATION (City, town, or county) (State) <u>MILAN (RURAL) MO</u>
24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>[Address]</u>	25. DATE RECD. BY LOCAL REG. <u>9-27-63</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. M.W. Beckett</u>

USE BLACK INK OR TYPEWRITER RIBBON

OCT 1 1963

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 *Richard D. Duggan*

Licensed Embalmer No. 3792

P. O. Address *Mela 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.