THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000501
STATE FILE NUMBER

FILED FEB 2 1959 Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 30

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH
a. COUNTY: Cape
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Cape Girardeau — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Francis Hosp. — Length of stay in Hospital: 7 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: Scott
c. CITY OR TOWN: Sikeston — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside city give location): 203 So. Handy — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Luther — Middle: Finis — Last: Jones

4. DATE OF DEATH: Month 1 — Day 19 — Year 1959

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 8, 1884

9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months 6, Days 21 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (City and state or country): Del Green, Del.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Finis Jones

13b. MOTHER'S MAIDEN NAME: Ellen Trotter

14. NAME OF HUSBAND OR WIFE: Mary Jones

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: Jesse Jones — Address: Sikeston, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 17772
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Hypertensive Cardiovascular Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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 ☐ **NOT WHILE AT WORK** ☐

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 7-14-56 to 1-19-59 and last saw ~~her~~ him alive on 1-19-59
Death occurred at 3:00 a.m. (1-19-59) from the causes stated on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): L.R. Seabaugh, M.D.

22b. ADDRESS: 219 North Pacific, Cape Girardeau, Missouri

22c. DATE SIGNED: 1-23-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 1-22-1959

23c. NAME OF CEMETERY OR CREMATORY: Forest Hill Memorial Gardens

23d. LOCATION (City, town, or county) (State): Manley, Mo.

24. FUNERAL DIRECTOR — **ADDRESS**: Albritton Funeral Home, Sikeston, Mo.

25. DATE RECD. BY LOCAL REG.: Jan. 29, 1959

26. REGISTRAR'S SIGNATURE: Mrs. Homer Cooper

(Licensed Embalmer's Statement on Reverse Side)

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 Raymond L. Duffie

Licensed Embalmer No. 4798

P. O. Address Bernie, 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.