Health, Welfare Public Service

300 C -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008039
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 29

1. PLACE OF DEATH a. COUNTY Saline b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARSHALL Shackelford — Inside Limits Yes ☒ No ☐ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION John Fitzgibbon — Length of stay in 1b 1day	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline c. CITY OR TOWN Shackelford 0970 C — Inside Limits Yes ☐ No ☒ d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
Frank		Jones	Feb. 16, 1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male 2	Negro		Jan. 19, 1893	66		

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)	12. CITIZEN OF WHAT COUNTRY?
Farm Laborer	Farming	Saline County, Mo. C	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
James Jones	Elizebath UNknown	unknown

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 Address
no.	none	Mrs. Mayme Jackson, Marshall, Missouri

MEDICAL CERTIFICATION

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)	Uremic Coma	20 days
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) Hypertension 444X

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 Feb 10 1959, to Feb. 16, 1959 and last saw him alive on Feb. 16, 1959
Death occurred at 11:00 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Robert D. Rayner M.D.	Marshall Mo	2/18/59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	2/21/59	Fairview Cemetery	Marshall, Missouri

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Geo. McGee, Marshall Mo.	2-18-59	Cecil V. Reed

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

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 ..... Signed .....

Signature of Student Embalmer

Licensed Embalmer No. 4220

P. O. Address Marshall, T

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.