

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048631

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 380 Primary Registration District No. 3089 Registrar's No. 521

FILED JAN 2 1964

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>OR</u> TOWN <u>Brookfield</u>		Length of stay in 1b <u>I year</u>	c. CITY OR TOWN <u>New Cambria</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>McLarney Manor</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Clara Grant Jones</u>			4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>1963</u>
5. SEX <u>Female</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>10/5/74</u>
9. AGE (last birthday) <u>89</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>9</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and state or country) <u>New Cambria, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>Owen W. Jones</u>	
13b. MOTHER'S MAIDEN NAME <u>Libbie Cole</u>		14. NAME OF HUSBAND OR WIFE <u>John B. Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u></u>)		16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT Address <u>J. Bert Jones, New Cambria, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemic Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>1 wk.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Smility</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>	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.) <u></u>		20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u> STATE <u></u>
21. I attended the deceased from <u>12-5-63</u> to <u>12-14-63</u> and last saw her alive on <u>12-14-63</u> . Death occurred at <u>12:15 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. W. Bohman M.D.</u> (Degree or title)		22b. ADDRESS <u>Brookfield Mo.</u>	22c. DATE SIGNED <u>12/15/63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/16/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cambria Cemetery</u>	23d. LOCATION (City, town, or county) <u>New Cambria, Mo.</u> (State)
24. FUNERAL DIRECTOR <u>H. G. Willard New Cambria Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>12/16/63</u>	26. REGISTRAR'S SIGNATURE <u>Anna Wilson</u>

USE BLACK INK OR TYPEWRITER RIBBON

FEB 18 1964

FEB 14 1964

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 *J. H. Leland*

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.