

1. PLACE OF DEATH a. COUNTY Travis		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) STATE COUNTY Texas Travis	
b. CITY OR TOWN (If outside city limits, give precinct no.) Austin		c. LENGTH OF STAY in l. b. 5 years	
d. NAME OF (If not in hospital, give street address) HOSPITAL OR INSTITUTION 2602 Penny Lane #109		d. STREET ADDRESS (If rural, give location) 2602 Penny Lane #109	
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		e. IS RESIDENCE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (a) First ROBERT (b) Middle PRESTON (c) Last JONES		4. DATE OF DEATH February 19, 1979	
5. SEX Male	6. COLOR OR RACE Caucasian	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1951
9. AGE (In years last birthday) 27		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Minutes	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Stillwater, Oklahoma		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard L. Jones		14. MOTHER'S MAIDEN NAME Mary Chancallor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 440-54-1236	
17. INFORMANT Mary Jones (Mother)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 MAR 16 1979			
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 building, etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____ and last saw the deceased alive on _____ 19____. Death occurred at _____ 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			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal for burial		23b. DATE February 19, 1979	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery			
23d. LOCATION (City, town, or county) (State) Muskogee, Oklahoma		24. FUNERAL DIRECTOR'S SIGNATURE John W. Amey (5427) WILKINSON FUNERAL HOME, INC.	
25a. REGISTRAR'S FILE NO. 324		25b. DATE REC'D BY LOCAL REGISTRAR FEB 21 1979	
25c. REGISTRAR'S SIGNATURE a. Meisenbach M.D. AUSTIN, TEXAS			

BUREAU OF VITAL STATISTICS
TEXAS DEPARTMENT OF HEALTH
MEDICAL CERTIFICATION

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