

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11553

FILED MAY 2 1949

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 473

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson 49</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>3yrs 6mo 25day</u>		d. STREET ADDRESS (If rural, give location) <u>14509 Wyoming St., 1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital no 2 2</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>John</u>	b. (Middle) <u>I.</u>	c. (Last) <u>Jones</u>	4. DATE OF DEATH (Month) (Day) (Year)
	<u>John</u>	<u>I.</u>	<u>Jones</u>	<u>April 23 1949</u>

5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb. 5 - 1878</u>	9. AGE (In years last birthday) <u>71</u>	if UNDER 1 YEAR Days <u>2</u>	if UNDER 24 Hrs. Hours <u>18</u>	if UNDER 1 Min. Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>fireman - Palmyra</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>city service</u>	11. BIRTHPLACE (State or foreign country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>D</u>				

13a. FATHER'S NAME <u>Patrick Jones</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Glavin</u>	14. NAME OF HUSBAND OR WIFE <u>Anna V. Jones</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Bathie Jones K. 6 Mo.</u>	ADDRESS <u>4509 Wyoming</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>33</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from April 1, 1949, to April 23, 1949, that I last saw the deceased alive on April 22, 1949, and that death occurred at 5:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John Thomas M.D.</u>	23b. ADDRESS <u>St. Joseph Mo 916 State Hosp 202</u>	23c. DATE SIGNED <u>4/23-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>April 26-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Apr 27, 1949</u> <u>E. K. Jenkins</u>	3820	25. FUNERAL DIRECTOR'S SIGNATURE <u>Deurk and Robin Co</u>	ADDRESS <u>20th Lem</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Signed Maudie Adair _____

Signed _____
Student Embalmer

Licensed Embalmer No. 4016 _____

P. O. Address 244 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 this body is not embalmed, fact should be so stated above.