

FILED OCT 10 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 29673

BIRTH NO. _____		REG. DIST. NO. <u>72</u>		PRIMARY REG. DIST. NO. <u>5289</u>		Registrar's No. <u>102</u>		
1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Gallatin</u>		c. LENGTH OF STAY (In this place) <u>All life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Gallatin</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pleasant Valley District</u>				d. STREET ADDRESS (If rural, give location) <u>Pleasant Valley District</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Calhoun</u> b. (Middle) _____ c. (Last) <u>Jones</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 16 1949</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 25- 1861</u>		9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>21</u>	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>Dr. Leander J. Jones</u>			13b. MOTHER'S MAIDEN NAME <u>Caroline Fish</u>		14. NAME OF HUSBAND OR WIFE <u>Ida</u>			
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'S SIGNATURE OR NAME ADDRESS <u>Lester Jones - R.F.D.#2 Liberty, Mo.</u>				
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, asthma, 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>Shock</u>							18 Hours	
ANTECEDENT CAUSES  DUE TO (b) <u>Fracture of Hip</u>								
DUE TO (c) _____								
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							<u>29:10</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT (Specify) SUICIDE HOMICIDE <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Gallatin, Clay Mo.</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Sept 15 '49</u> m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall</u>				
22. I hereby certify that I attended the deceased from <u>9-15-49</u> , 19 <u>49</u> , to <u>9-16</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>9-15</u> , 19 <u>49</u> , and that death occurred at <u>7:30</u> a.m., from the causes and on the date stated above. <u>9-16-49</u>								
23a. SIGNATURE (Degree or title) <u>Lester Jones M.D.</u>				23b. ADDRESS <u>Claycomo Addition, No. K.C.</u>		23c. DATE SIGNED <u>Mo 9-16-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 19-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		24d. LOCATION (City, town, or county) (State) <u>Liberty Mo.</u>			
DATE REC'D BY LOCAL REG. <u>Sept 19-49</u>		REGISTRAR'S SIGNATURE <u>Beulah Kitchener</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Church - Ocean Co. Liberty Mo.</u>				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

OCT 8

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 10-8-49

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. \_\_\_\_\_

Signed John L. Lohman

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4448

P. O. Address Liberty

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.