

FILED JAN 5 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41670
5469

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City	c. LENGTH OF STAY (In this place) 3 S.	c. CITY (If outside corporate limits, write RURAL and give township) Leawood 8150	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If rural, give location) 9301 Meadow Lane	

3. NAME OF DECEASED (Type or Print) a. (First) OLLIE	b. (Middle) V.	c. (Last) JONES	4. DATE OF DEATH (Month) (Day) (Year) 12 18 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Dec. 7, 1880	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Saline, Co., Mo.	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME William Holt	13b. MOTHER'S MAIDEN NAME Jennie Norvell	14. NAME OF HUSBAND OR WIFE Roy E. Jones
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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. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. J. O. McClay, 9301 Meadow Lane, Leawood
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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 2021
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) (MALIGNANT) LYMPHOBLASTOMA ANTECEDENT CAUSES Probable retroperitoneal lymphatic metastasis to peritoneal and retroperitoneal cavities. (b) ORIGINEE GENERALIZED METASTASIS TO PERITONEAL AND RETROPERITONEAL CAVITIES (c) AND RETROPERITONEAL CAVITIES		

19a. DATE OF OPERATION 0	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) 0	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. 0	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 **1930**, 19, to **Dec 18, 1951**, that I last saw the deceased alive on **Dec 18, 1951**, and that death occurred at **2 P** m., from the causes and on the date stated above.

23a. SIGNATURE P. C. Quistgard MD (Degree or title)	23b. ADDRESS 694 Prospect Ave, Leawood	23c. DATE SIGNED Dec 19 1951
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/20/51	24c. NAME OF CEMETERY OR CREMATORY Mt. Washington	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. 12-19-51	REGISTRAR'S SIGNATURE Seraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS FREEMAN MORTUARY & CHAPEL, K.C., MO.
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WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

1818

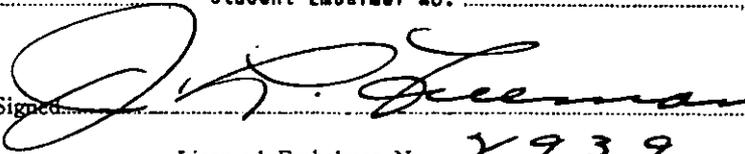
STATEMENT BY LICENSED EMBALMER

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
Student Embalmer

Signed 

Licensed Embalmer No. 2939

P. O. Address F. O. W. C.

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.