

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12370**

FILED MAY 13 1952

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BIRTH NO. _____		REG. DIST. NO. <u>91</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>51</u>	
1. PLACE OF DEATH a. COUNTY <u>CLAY</u>				2. USUAL RESIDENCE (Where deceased lived). If institution: residence before admission. a. STATE <u>IOWA</u> b. COUNTY <u>LUCAS</u>			
b. CITY OR TOWN <u>EXCELSIOR SPRINGS</u>		c. LENGTH OF STAY (in this place) <u>3 WKS.</u>		c. CITY OR TOWN <u>CHARITON</u>		<u>8140</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>EXCELSIOR SPRINGS HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>1536 LINDEN AVENUE</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Carl</u> b. (Middle) _____ c. (Last) <u>Jones</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 8, 1952</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SEPARATED</u>	8. DATE OF BIRTH <u>JULY 16, 1879</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 WKS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MINER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COAL MINING</u>		11. BIRTHPLACE (State or foreign country) <u>SWEDEN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>JONAS PETERSON</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>MINNIE OTTO</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT'S SIGNATURE OR NAME <u>DAVID JONES</u> ADDRESS <u>3315 WHELUETT AVE MINNEAPOLIS, MINN.</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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>35'</u>
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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>4201</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-8, 1952</u> , to <u>4-8, 1952</u> , that I last saw the deceased alive on <u>4-8, 1952</u> , and that death occurred at <u>12.45 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>George E. Sander M.D.</u> (Degree or title)				23b. ADDRESS <u>Excelsior Springs Mo.</u>		23c. DATE SIGNED <u>4-8-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>4-9-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>UNKNOWN</u>		24d. LOCATION (City, town, or county) (State) <u>CHARITON, IOWA</u>		
DATE REC'D BY LOCAL REG. <u>4/9/52</u>		REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Claude Richard</u>		ADDRESS <u>Excelsior Springs, Mo.</u>	

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

MAY 14 1922

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 *Lindell K. Jansen*

Licensed Embalmer No. *4589*

P. O. Address *Excelsior Springs, 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.