

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35044**
4109

FILED OCT 25 1952

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) Kennett City		c. CITY (If outside corporate limits, write RURAL and give township) Joplin	
c. LENGTH OF STAY (in this place) 12 days		d. STREET ADDRESS (If rural, give location) 717 W 14	
d. FULL NAME OF HOSPITAL OR INSTITUTION The Childrens Mercy			

3. NAME OF DECEASED (Type or Print) a. (First) MARLYN b. (Middle) Louise c. (Last) JAYNES	4. DATE OF DEATH (Month) (Day) (Year) 9-18-52
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5. SEX F	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH 12-13-48	9. AGE (In years last birthday) 3 if under 1 year: Months _____ Days _____ if under 48 hrs: Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) Joplin MO	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Eugene Jaynes	13b. MOTHER'S MAIDEN NAME Jennie PIERCE	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mo. ADDRESS Mr. Eugene Jaynes, 717 W. 14th St., Joplin
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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, 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) Acute Hemulocytosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Neuroblastoma with metastasis 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	20. AUTOPSY? YES <input checked="" 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)	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 **9-6** **1952** to **9-18, 1952**, that I last saw the deceased alive on **9/18, 1952**, and that death occurred at **3:50 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE H. M. Gilkey (Degree or title) M.P.	23b. ADDRESS 1624 Prof Bldg	23c. DATE SIGNED 9/18/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9/18/52	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) Joplin MO
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DATE REC'D BY LOCAL REG. 9-18-52	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Stine ADDRESS M. Ch. Lane K.C. Mo
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(Licensed Embalmer's Statement on Reverse Side)

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.

Student

Student Embalmer

Signed

Eugene L. Lemon

Licensed Embalmer No. *4633*

P. O. Address *Louisville, Ky.*

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

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