

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. ....

S. No. 300

v. 10-48

FEB MAR 9 - 1953

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>277</u>	
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>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Joseph</u>			c. LENGTH OF STAY (In this place) <u>49 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>			<u>0112</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>231 1/2 Ohio St.</u>				d. STREET ADDRESS (If rural, give location) <u>231 1/2 Ohio St.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>MELLIE</u>		b. (Middle) <u>SUSAN</u>		c. (Last) <u>JONES</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Nov 22, 1868</u>	
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 10 HRS. Hours _____ Min. _____		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 27, 1953</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Frankfort County, Ky.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>James Elijah Kabler</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Wright</u>			14. NAME OF HUSBAND OR WIFE <u>Edwin F. Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME City ADDRESS <u>Mrs Ernest Steinbrenner, 231 1/2 Ohio</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
<p><i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i></p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Heart Disease</u>					<u>1 day</u>
		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Embolism Popliteal Artery</u> <u>Right Leg</u> DUE TO (c) <u>Chronic Valvular Heart Disease</u>					<u>3 yrs.</u>
19a. DATE OF OPERATION		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 type="checkbox"/> NO <input checked="" 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) (m.)		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>Feb 26</u> , 19 <u>53</u> , to <u>Feb 27</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Feb 27</u> , 1953, and that death occurred at <u>6:00A.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. J. R. Jones, M.D.</u>				23b. ADDRESS <u>134 Ill. Ave.</u>		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Mar 2-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Mora Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo. 2/28/53</u>		
DATE REC'D BY LOCAL REG. <u>March 5, 1953</u>		REGISTRAR'S SIGNATURE <u>Carl C. Casp</u>		446		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ever &amp; Clark 120 Illinois</u>	

(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 *Emma Clark*

Licensed Embalmer No. 4238

P. O. Address *St. Joseph, 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.