

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

38363

State File No.

300
48

FILED NOV 23 1953

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>4053</u>		Registrar's No. <u>1180</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Buchanan</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>De Kalb</u>			c. LENGTH OF STAY (in this place) <u>80 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>DeKalb</u>			<u>0110</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DeKalb, Mo.</u>				d. STREET ADDRESS (If rural, give location) <u>General Delivery</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Naomi</u>			b. (Middle)		c. (Last) <u>Jones</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 11, 1953</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>May 8, 1868</u>		9. AGE (In years last birthday) <u>85</u>	10. UNDER 1 YEAR <u>6</u> Months	11. UNDER 24 HRS. <u>3</u> Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Platte County MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Miller</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Brown</u>		14. NAME OF HUSBAND OR WIFE <u>Amos L. Jones (De)</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>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Fred Eastbourne DeKalb, Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>							<u>3 days</u>
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				DUE TO (b) <u>Cerebral Arteriosclerosis</u>			<u>1 1/2 yrs.</u>
				DUE TO (c) <u>Generalized Arteriosclerosis</u>			<u>unknown</u>
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)		<u>332 X</u>	
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>Nov. 2, 1953</u> , to <u>Nov. 21, 1953</u> , that I last saw the deceased alive on <u>Nov. 2, 1953</u> , and that death occurred at <u>8 a. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Thomas E. Wagner M.D.</u>				23b. ADDRESS <u>301 Illinois Ave. St. Joe, Mo.</u>		23c. DATE SIGNED <u>11-12-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11/13/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Westlawn Cemetery DeKalb, Mo.</u>		24d. LOCATION (City, town, or county) (State) <u>Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Nov 16, 1953</u>		REGISTRAR'S SIGNATURE <u>Arthur M. Allison</u>		GENERAL DIRECTOR'S SIGNATURE <u>John E. Kupp</u>		ADDRESS <u>St. Joseph, Mo.</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 *Alvin E. Bazar*

Licensed Embalmer No. *4795*

P. O. Address *St. Joseph St.*

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.