

FILED JUN 21 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18008

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 626

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>Agency</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>life</b>		e. STREET ADDRESS (If rural, give location) <b>0110</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Methodist Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Harvey</b>	b. (Middle) <b>Jefferson</b>	c. (Last) <b>Jones</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 10, 1954</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>November 18, 1883</b>	9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret. manager</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Match Company</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Buchanan County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William H. Jones</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Ellen Auxier</b>	14. NAME OF HUSBAND OR WIFE <b>Matilda</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>495-01-8239</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Matilda Jones, Agency, Mo.</b>	ADDRESS
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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 <b>?</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Atherosclerosis, gen.</b>		
	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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.)	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 Oct, 1952, to June 10, 1954, that I last saw the deceased alive on 6-10, 1954, and that death occurred at 11:04p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>W. D. Carl</b>	23b. ADDRESS <b>706 Francis St. Joseph Mo.</b>	23c. DATE SIGNED <b>6-11-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>6/13/1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Agency Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Agency, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>June 19, 1954</b>	REGISTRAR'S SIGNATURE <b>Robert M. Allison</b>	485	25. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Bowman</b>	ADDRESS <b>St. Joseph Mo.</b>
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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.....  
Signature of Student Embalmer

Signed *William Spalding*.....  
Licensed Embalmer No. *4535*.....

P. O. Address *3198 108 St*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.