

FILED OCT 25 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34253

State File No.

BIRTH NO. REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 408

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Independence</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Buckner</u>	
c. LENGTH OF STAY (In this place) <u>6 weeks</u>		d. STREET ADDRESS (If rural, give location) <u>NW of TOWN 3 miles</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Sanitarium</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>L.</u>	b. (Middle) <u>J.</u>	c. (Last) <u>Jones</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 12. 1954</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 18. 1882</u>	9. AGE (In years last birthday) Months Days <u>72 1 24</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>his own farm</u>	11. BIRTHPLACE (State or foreign country) <u>Matthews Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>John W Jones</u>	13b. MOTHER'S MAIDEN NAME <u>Teresa Moorman</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Mina Jones</u>
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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>no</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mina Jones Buckner Mo.</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>65 days</u> <u>2 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u> <u>Left sided hemiplegia in Antecedent Cause</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Due to (b) Arteriosclerosis & Myocardial</u> <u>Due to (c)</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 <u>332 X</u>	20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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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 Aug 9 - 1954, to 10-12-- 1954, that I last saw the deceased alive on 10-12-- 1954 and that death occurred at 9 P.M. from the causes and on the date stated above.

23a. SIGNATURE <u>C. H. Allen</u>	(Degree or title) <u>MD</u>	23b. ADDRESS <u>Independence Mo.</u>	23c. DATE SIGNED <u>Oct. 14. 54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>Oct. 15. 54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Buckner Hill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Buckner, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>10-13-54</u>	REGISTRAR'S SIGNATURE <u>James H. Gray</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Vernon M. Kappert Buckner Mo.</u>
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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 _____

working under my personal supervision. _____
Student Embalmer No. _____

Student
Student Embalmer

Signed _____
Licensed Embalmer No. _____

P. O. Address _____

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.