

FILED JAN 12 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41025**

Registrar's No. **5834**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>5834</u>	
1. PLACE OF DEATH a. COUNTY @ <b>JACKSON!</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>KANSAS</b> b. COUNTY <b>Bourbon</b>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>KANSAS CITY</b> )		c. LENGTH OF STAY (in this place) <b>2 1/2 Months</b>		c. CITY OR TOWN <b>IOLA</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				* STREET ADDRESS (If rural, give location) <b>624 SOUTH STREET</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>JOSEPH</b> b. (Middle) <b>CLARENCE</b> c. (Last) <b>JONES</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>December 20, 1954</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>October 4, 1897</b>	
9. AGE (10 years last birthday) <b>57</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b>		IF UNDER 24 HRS. Hours <b>2</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Springfield, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Oliver Jones</b>			13b. MOTHER'S MAIDEN NAME <b>H Anna Old</b>		14. NAME OF HUSBAND OR WIFE <b>--</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>513-10-7012</b>		17. INFORMANT'S SIGNATURE OR NAME <b>VA Hospital Official Record, K.C. Mo.</b>			
(If yes, give war or dates of service) <b>WWII</b>							
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Infarct rt. cerebral hemisphere, massive</b>  ANTECEDENT CAUSES DUE TO (b) <b>Thrombosis, basilar artery with occlusion</b> DUE TO (c) <b>Generalized arteriosclerosis</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH  <b>332</b>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <b>VA</b>		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 <b>October 4, 1954</b> , to <b>December 20, 1954</b> , <del>XXXXXXXXXXXXXXXXXXXX</del> and that death occurred at <b>12:30 Am.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>W. E. Burger, M.D.</b> (Degree or title)				23b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		23c. DATE SIGNED <b>12/20/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Dec. 22, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <b>IOLA KANSAS</b>	
DATE REC'D BY LOCAL REG. <b>12-21-54</b>		REGISTRAR'S SIGNATURE <b>Neve Marshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>D. W. NEWSOMER'S SONS K.C. Mo.</b>			

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

125th St. N. W.  
1914

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. *Edward M. Stone*

Licensed Embalmer No. *443*

P. O. Address *K. C. 10*

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.