

FILED JUL 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23194**

BIRTH NO. _____ REG. DIST. NO. **280** PRIMARY REG. DIST. NO. **6-964** Registrar's No. **44**

1. PLACE OF DEATH a. COUNTY PLATTE COUNTY, MO		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN RIVERSIDE Pott. 2 mi. S.E.) c. LENGTH OF STAY (in this place) 2.5 YRS.		c. CITY OR TOWN KANSAS CITY	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 PLATTE COUNTY, MO		e. STREET ADDRESS (If rural, give location) 803 W. 54th TERR. 3721	

3. NAME OF DECEASED (Type or Print) a. (First) THOMAS b. (Middle) DANIEL c. (Last) JONES			4. DATE OF DEATH (Month) (Day) (Year) JULY 12, 1955		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED: NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH March 28, 1927	9. AGE (In years last birthday) 28	10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PILOT		10b. KIND OF BUSINESS OR INDUSTRY BAKER FLYING	11. BIRTHPLACE (City and State or Foreign Country) CHICAGO, ILLINOIS	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME LEM T. JONES	13b. MOTHER'S MAIDEN NAME JESSIE STOVER	14. NAME OF HUSBAND OR WIFE _____
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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) YES W.W. II	16. SOCIAL SECURITY NO. 497-28-0684	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS LEM T. JONES 803 W. 54th TERR. Kansas City, Mo.
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MULTIPLE SKULL FRACTURE AND MULTIPLE COMPOUND FRACTURES		
	ANTECEDENT CAUSES AND MULTIPLE COMPOUND FRACTURES 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. PLANE CRASH 866x			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 39	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) ACCIDENT	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NEAR FAIRFAX BRIDGE, PLATTE, MO.	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 082 (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input checked="" 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 **APPROX 19** _____, to _____, 19 _____, that I last saw the deceased alive on _____, 19 _____, and that death occurred at **10:15 AM.**, from the causes and on the date stated above.

23a. SIGNATURE Roland M. Giffey, Coroner (Degree or title)	23b. ADDRESS Platte City	23c. DATE SIGNED 7/12/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 7/15/55	24c. NAME OF CEMETERY OR CREMATORY MT. MORIAH	24d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.
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DATE REC'D BY LOCAL REG. July 12, 55	REGISTRAR'S SIGNATURE R. Phia Rollins 257	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS FREEMAN MORTUARY K. C., Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD



AUG 3 1955

MAY 19 1964

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by Student Embalmer No.....

working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Mar. W. Lickendoll*

Licensed Embalmer No. *463*

P. O. Address *K. C., M.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa 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.