

THE DIVISION OF HEALTH OF MISSOURI  
FILED JUN 13 1956 STANDARD CERTIFICATE OF DEATH

State File No. **16424**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **2210**

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>Crawford</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>	c. LENGTH OF STAY (in this place) <b>6 days</b>	c. CITY OR TOWN <b>Arcadia</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>Menorah Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>??????</b> <b>§1501</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>George</b>	b. (Middle)	c. (Last) <b>Jones</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>May 20 1956</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>Sept 28 1879</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Arcadia Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Francis Jones</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Mock</b>	14. NAME OF HUSBAND OR WIFE <b>Jessie Jones <del>Tosid</del></b>
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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) <b>No</b>	16. SOCIAL SECURITY <b>511 32-5925</b>	17. INFORMANT'S SIGNATURE OR NAME <b>John C. Jones Arcadia Kas.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cancer of Rectum</b>		INTERVAL BETWEEN ONSET AND DEATH  <b>1 yr?</b>  <b>154x</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. <b>Cardiac failure Auricular fibrillation</b>		

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)
21d. TIME (Month) (Day) (Year) (Hour)	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 **10 May, 1956**, to **20 May, 1956**, that I last saw the deceased alive on **20 May, 1956**, and that death occurred at **3:15 P.M.** from the causes and on the date stated above.

23a. SIGNATURE <b>Philip H. Halperin M.D.</b> (Degree or title)	23b. ADDRESS <b>701 E 63rd - K.C. Mo</b>	23c. DATE SIGNED <b>21 May '56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Mar 22 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Sheffield</b>	24d. LOCATION (City, town, or county) (State) <b>Arcadia, Kansas</b>
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DATE REC'D BY LOCAL REG. <b>5-21-56</b>	REGISTRAR'S SIGNATURE <b>neva minahell</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs C.L. Forster</b>	ADDRESS <b>r Funeral Home Kas. C. Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 13 1956

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 *J. Virgil Harriell*.....  
Licensed Embalmer No. 35

P. O. Address *A. C. M.*.....

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.