

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26977

STATE FILE NUMBER

FILED AUG 29 1956

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3403

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital #1</b>			Length of stay in lb <b>5 Yrs.</b>	13 <sup>d</sup> . STREET ADDRESS <b>609 E. 9th</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>James L. Jones</b>				First	Middle	Last	4. DATE OF DEATH Month <b>8/</b> Day <b>4</b> Year <b>56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/18/84</b>		9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>House Painting</b>		11. BIRTHPLACE (City and state or country) <b>Cave City, Ark.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Houston Jones</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Morris</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> <b>X</b> <b>X</b> <b>X</b>			16. SOCIAL SECURITY NO. <b>430 28 4249</b>	17. INFORMANT Address <b>Mrs. E. Hansen 6903 E. 113 Terrace.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Retroperitoneal tumor</b>							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Cancer of bladder</b>					181X	
		DUE TO (c)						
PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <b>8/2/56</b> to <b>8/4/56</b> and last saw her/him alive on <b>8/4/56</b> <input checked="" type="checkbox"/> Death occurred at <b>2:28</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>B. I. Burns, M.D.</b>				22b. ADDRESS <b>24th and Cherry</b>			22c. DATE SIGNED <b>8/4/56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8/5/56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Batesville</b>		23d. LOCATION (City, town, or county) <b>Batesville, Ark.</b>		(State)	
24. FUNERAL DIRECTOR ADDRESS <b>FLORAL HILLS MEMORIAL CHAPELS K.C. Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>8-5-56</b>		25. REGISTRAR'S SIGNATURE <b>Neve Minshall</b>		

(Licensed Embalmer's Statement on Reverse Side)

Health, welfare, public service

800-56

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *Raymond C. McCord*

Licensed Embalmer No. *485*

P. O. Address *N. C. 71*

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