

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26978

FILED AUG 29 1956

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3188

1. PLACE OF DEATH

a. COUNTY

Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)

TOWN Kansas City

Inside Limits
Yes No

c. CITY OR TOWN Kansas City

Inside Limits
Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital

Length of stay in lb 70 yrs

d. STREET ADDRESS (If outside, give location) 82 6151 Locust

Reside on Farm
Yes No

3. NAME OF DECEASED (Type or print)

ROBERT

T.

JONES

4. DATE OF DEATH
Month Aug Day 7 Year 1956

5. SEX

Male

6. COLOR OR RACE
White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Jan 21, 1883

9. AGE (In years last birthday)
73

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)
Sales Manager

10b. KIND OF BUSINESS OR INDUSTRY
Paint

11. BIRTHPLACE (City and state or country)
Fort Scott, Kansas

12. CITIZEN OF WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

Enoch Jones

14. MOTHER'S MAIDEN NAME

JEAN Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
None

16. SOCIAL SECURITY NO.
495-01-2185

17. INFORMANT
Anna Jones Address 6151 Locust

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial Failure

INTERVAL BETWEEN ONSET AND DEATH
2 wks

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Posterior Coronary Infarction

July 25, 56

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Abdominal Aortic Aneurysm for over 4 yrs.

19. WAS AUTOPSY PERFORMED?
YES NO

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour _____ a. m. _____ p. m. _____
Month _____ Day _____ Year _____

20d. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

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 July 25 56 to Aug 7 56 and last saw her alive on Aug 7 56.
Death occurred at 10:40 PM _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Glen H. Broyles

(Degree or title)

MD

22b. ADDRESS

1232 Biographical Bldg

22c. DATE SIGNED
8-9-56

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

8-10-56

23c. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

23d. LOCATION (City, town, or county)

Hickman Mills

(State)

Missouri

24. FUNERAL DIRECTOR

ADDRESS

Melody-McGilley-Eylar 1800 E. Linwood

25. DATE RECD. BY LOCAL REG.

8-9-56

26. REGISTRAR'S SIGNATURE

Neva Minshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Glen H. Broyles, M.D.

MEDICAL CERTIFICATION

Dr. Boyles
Chgo. Ill.
No. 4420
11-16-11

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.....


Licensed Embalmer No. 2999

P. O. Address..... 150

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.