

health, Welfare, Public Service
 300
 1-56
 All 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 listed.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 3 1956

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

37159

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 4053 Registrar's No. 1244

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>De Kalb</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>De Kalb</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>De Kalb Public Health Hospital</i> Length of stay in hospital <i>2 Months</i>		d. STREET ADDRESS (If outside, give location) <i>Rural Route #1</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>JAMES</i> Middle <i>D.</i> Last <i>JONES</i>			4. DATE OF DEATH Month <i>Nov.</i> Day <i>18</i> Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 13, 1874</i>
9. AGE (In years last birthday) <i>82</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	10c. BIRTH PLACE (City and state or country) <i>Weston, Missouri</i>
11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>T.C. Jones</i>		14. MOTHER'S MAIDEN NAME <i>Mauda Scott</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown. If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. ANNEURMANT Address <i>Maud Jones Syc, Weston, Mo.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Cerebral Arteriosclerosis</i>			<i>unknown</i>
DUE TO (c) <i>Arteriosclerosis</i>			<i>unknown</i>
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 type="checkbox"/> NO <input checked="" 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 <i>3:15</i> Month <i>AM</i> Day <i>AM</i> Year <i>AM</i>			
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 <i>December 12-52</i> to <i>Nov 18, 1956</i> and last saw her alive on <i>Nov 2, 1956</i> Death occurred at <i>3:15 AM</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Sharon E. Waggoner, M.D.</i>		22b. ADDRESS <i>301 Illinois Ave St. Joseph, Missouri</i>	22c. DATE SIGNED <i>11-23-56</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Nov. 20, 1956</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Graceland Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Weston Missouri</i>
24. FUNERAL DIRECTOR ADDRESS <i>Lavin Syc, Atchison, Kansas</i>		25. DATE RECD. BY LOCAL REG. <i>Nov. 27, 1956</i>	26. REGISTRAR'S SIGNATURE <i>Ethel M. Allison</i>

(Licensed Embalmer's Statement on Reverse Side)

1934

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, ~~or~~ by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
J. Meyer

Licensed Embalmer No. 43

P. O. Address *Atchafalaya*

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.