

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 11 1957

37726
STATE FILE NUMBER
Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 215

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u> ⁶¹¹³ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If not Missouri give location) HOSPITAL OR INSTITUTION <u>Methodist Hospital</u>		Length of stay in lb <u>40 yrs</u>	
		d. STREET ADDRESS (If outside, give location) <u>1519 St. Joseph Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>ELIZABETH</u> Last <u>JONES</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27, 1895</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wyeth Co.</u>	11. BIRTHPLACE (City and state or country) <u>New Cambria Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>William A. Jones</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Williams</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>491-09-3390</u>	17. INFORMANT <u>Evan D. Jones</u> Address <u>St. Joseph, Mo.</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the uterus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		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.) <u>1</u>	
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 Jan. 23, 1956 to February 24, 1957 and last saw her ~~her~~ ^{her} alive on Feb. 23, 1957
Death occurred at 3:30A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Allan Islerman MD</u>	22b. ADDRESS <u>706 Francis, St. Joseph, Mo.</u>	22c. DATE SIGNED <u>3-1-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-26-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cambria Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>New Cambria Missouri</u>
24. FUNERAL DIRECTOR <u>Stamey Funeral Home</u>	ADDRESS <u>St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>March 4, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>

(If Licensed Embalmer's Statement on Reverse Side)

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

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..... *Charles E. Bennett*

Licensed Embalmer No. *467*

P. O. Address *St. Joseph*

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