

Health, Welfare, Public Service

FILED AUG 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28272
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3682

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-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General #2</u>		Length of stay in lb <u>25yrs</u>	d. STREET ADDRESS (If outside, give location) <u>2404 E 12th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Archie</u> Middle _____ Last <u>Jones</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 1901</u>
9. AGE (In years last birthday) <u>56</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Arkansas</u>
12. CITIZEN OF THAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Tom Jones</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Laura Jones</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>496-16-9340</u>	17. INFORMANT Address <u>Naomi Copeland 2713 Indiana</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>Terminal bronchical pneumonia.</u> DUE TO (b) <u>Possible bronchogenic carcinoma, with metastasis</u> DUE TO (c) <u>to right chest wall and right inguinal region.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>162x</u>
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____	
20d. INJURY OCCURRED WHILE AT <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 <u>June 22, 1957</u> to <u>August 3, 1957</u> and last saw her alive on <u>August 3, 1957</u> Death occurred at <u>4:05</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>H. R. Peterson M.D.</u> (Degree or title) <u>D</u>		22b. ADDRESS <u>600 East 22nd Street</u>	22c. DATE SIGNED <u>8-6-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/7/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Manlove & Williams 1729 Lydia</u>		25. DATE RECD. BY LOCAL REG. <u>8-6-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

W. R. Peters on

AP 2

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

Maynard Weller

Licensed Embalmer No. 4653

P. O. Address A E Mo

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.