

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35930

STATE FILE NUMBER

FILED NOV 5 1957

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

4889

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) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. #1		d. STREET ADDRESS (If outside, give location) 3304 E. 10	
3. NAME OF DECEASED (Type or print) Vinton Jones		4. DATE OF DEATH Month 10 Day 20 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 18, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - 2 YEARS		10b. KIND OF BUSINESS OR INDUSTRY DENTIST	
11. BIRTHPLACE (City and state or country) LEBO, KANSAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME GRIFFITH F JONES		13b. MOTHER'S MAIDEN NAME MARY WILLIAMS	
14. NAME OF HUSBAND OR WIFE MRS. PEGGY JONES		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. GRIFFITH E. JONES	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus with widespread metastases		INTERVAL BETWEEN ONSET AND DEATH 150*	
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)		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 _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____	
20f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. I attended the deceased from June 18, 1957 to Oct. 20, 1957 and last saw him alive on Oct. 20, 1957 Death occurred at 5:10 P. m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE [Signature] (Degree or title)		22b. ADDRESS 24th & Cherry	
22c. DATE SIGNED 10-21-57		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE OCT. 22, 1957		23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY	
23d. LOCATION (City, town, or county) KANSAS CITY MISSOURI		23e. (State) _____	
24. FUNERAL DIRECTOR DIAL NEWCOMER'S SONS ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 10-22-57	
26. REGISTRAR'S SIGNATURE [Signature]			

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 *Bernard L. Foster*

Licensed Embalmer No. *4250*

P. O. Address *NC 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.