

FILED DEC 11 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5477

S. 300
v. 1-57 0

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Grand view Kansas City 1 st
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Hospital		Length of stay in lb 15 days	d. STREET ADDRESS 14 1/2 Shelton (Give location) 5323 Holmes (If in hospital) No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WILLIAM Middle EDWARD Last JONES			4. DATE OF DEATH Month Nov. Day 19, Year 1957		
---	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 8, 1881	9. AGE (In years last birthday) 76	10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. UNDER 24 HRS. Hours 0 Min. 0
--------------------	-------------------------------	---	--	--	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) New Cambria, Mo.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	-----------------------------------	---	---

13a. FATHER'S NAME Ivan Jones	13b. MOTHER'S MAIDEN NAME Elizabeth (Unknown)	14. NAME OF HUSBAND OR WIFE Augusta Jones
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. -	17. INFORMANT Mrs. R. D. Messerschmidt, 14 1/2 Shelton Address Grandview, Mo.
--	-------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal insufficiency		INTERVAL BETWEEN ONSET AND DEATH 7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) acute pyelonephritis		9 days
DUE TO (c) Broncho pneumonia		1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease-condition given in PART I (a)		

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 11 a. Month 11 Day 19 Year 1957 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 Grandview, Mo.	COUNTY Jackson	STATE Missouri
--	---	--	---	--------------------------	--------------------------

21. I attended the deceased from 11-3-57 to 11-19-57 and last saw her alive on 11-19-57 . Death occurred at 11 a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. W. Leifer MD (Degree or title)	22b. ADDRESS 701 F 63 KC Mo	22c. DATE SIGNED 11-19-57
--	---------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial & Removal	23b. DATE 11-19-57	23c. NAME OF CEMETERY OR CREMATORY Macon Missouri Cemetery	23d. LOCATION (City, town, or county) (State) Macon, Mo.
--	------------------------------	--	--

24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home	ADDRESS 11-20-57	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE Neva Marshall
--	----------------------------	------------------------------	---

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
W. W. Leifer



Dr. Wm. W. Heifer
Doctors Bldg, Room 7
701 E 43'
Te 3-0500

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 *James W. Wair*

Licensed Embalmer No. *4650*
P. O. Address *K.C. 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.