

Health, Welfare, Public Service

FILED FEB 3 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1292
STATE FILE NUMBER
143

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

300
-57

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| 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 Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. #1 | | Length of stay in lb 10 yrs | d. STREET ADDRESS 3103 Beacon (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Charles Middle C. Last Jones | | | 4. DATE OF DEATH Month 1 Day 6 Year 1958 | | |
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|--------------------|-------------------------------|---|---|--|------------------------------|--------------------------------|
| 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 Oct 14, 1886 | 9. AGE (In years to birthday) 71 | FUNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY - | 11. BIRTHPLACE (City and state or country) Hancock Co. Tenn | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME John Jones | 13b. MOTHER'S MAIDEN NAME Nancy Bolen | 14. NAME OF HUSBAND OR WIFE Luvernie Jones |
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| 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 Luvernie Jones Address 3103 Beacon |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | 4250 |
| 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"/> |

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| 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.) |
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|---|---|--|---|-----------------------|--------------------|
| 20c. TIME OF INJURY Hour _____ 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 Beaumont | COUNTY Waco | STATE Mo |
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| 21. I attended the deceased from Jan. 5, 1958 to Jan. 6, 1958 and last saw ^{him} her alive on Jan. 6, 1958 Death occurred at 9 P. on the date stated above; and to the best of my knowledge, from the causes stated. | |
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| 22a. SIGNATURE B. J. Burris, M.D. (Degree or title) | 22b. ADDRESS 24th & Cherry | 22c. DATE SIGNED 1-7-58 |
|--|--|-----------------------------------|

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|---|-------------------------------|--|--|---------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE Jan 11-58 | 23c. NAME OF CEMETERY OR CREMATORY Brookside Cem | 23d. LOCATION (City, town, or county) Beaumont, Mo | (State) |
|---|-------------------------------|--|--|---------|

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| 24. FUNERAL DIRECTOR Kepler-Beaumont, Beaumont, Mo ADDRESS | 25. DATE RECD. BY LOCAL REG. 1-10-58 | 26. REGISTRAR'S SIGNATURE Evea Marshall |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

B. I. B. I. T. S.

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



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 *William L. Kopy*

Licensed Embalmer No. *4225*

P. O. Address *Ludger 20*

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.