Health, Welfare Public Service

300 1
-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-005631

STATE FILE NUMBER 823

FILED MAR 10 1958

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

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 1805 W. 39th St. — Length of stay in 1b 25 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1805 W. 39th St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First CLYDE Middle WILBUR Last JONES

4. DATE OF DEATH Month Feb Day 15 Year 1958

5. SEX Male 6. COLOR OR RACE White 7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] 8. DATE OF BIRTH May 1892 9. AGE (In years last birthday) 65 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) Painter & Paper Hanger 10b. KIND OF BUSINESS OR INDUSTRY Self-Contractor 11. BIRTHPLACE (City and state or country) Kansas City, Ks. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Wm. W. Jones 13b. MOTHER'S MAIDEN NAME Mary Ellen Kelly 14. NAME OF HUSBAND OR WIFE Clara Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I 16. SOCIAL SECURITY NO. 492-18-4877 17. INFORMANT Address Mrs. Maude Moreland, 1805 W. 39th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
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)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] 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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] 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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Hugh H. Owens (Degree or title) Coroner 22b. ADDRESS 1034 Rialto Bldg 22c. DATE SIGNED 2-15-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial & Removal 23b. DATE 2/18/58 23c. NAME OF CEMETERY OR CREMATORY National Cem. 23d. LOCATION (City, town, or county) (State) Leavenworth Kansas

24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home ADDRESS 1800 E. Linwood 25. DATE RECD. BY LOCAL REG. 2-15-58 26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Hugh H. Owens

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.