

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028506  
STATE FILE NUMBER

FILED SEP 3 1958 Registration District No. 59 Primary Registration District No. 5227 Registrar's No. 115

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|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Cass</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>California</u> b. COUNTY <u>Los Angeles</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Peculiar Twp</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  | c. CITY OR TOWN <u>Sun Valley</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                              |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VILLE AN 71BY-PASS</u> Length of stay in <input checked="" type="checkbox"/>                   |  | d. STREET ADDRESS (If outside, give location) <u>Box 8</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>    |  |

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| 3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>BOYD</u> Last <u>JONES</u> |  |  | 4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>58</u> |  |  |  |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 26 1913</u> | 9. AGE (In years) <u>44</u> IF UNDER 1 YEAR Months Days Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Operator</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Lawton Mo</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Frances M Jones</u> | 13b. MOTHER'S MAIDEN NAME <u>Matilda Baker</u> | 14. NAME OF HUSBAND OR WIFE <u>Sarah Letha Jones</u> |
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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) <u>no</u> | 16. SOCIAL SECURITY NO. <u>525-64-8214</u> | 17. INFORMANT <u>Castell Lim</u> Address <u>Bronaugh Mo.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRAIN TRAUMA</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>SUDDEN</u> |
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| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>SKULL FRACTURE</u> |
|  | DUE TO (c) <u>CAR ACCIDENT</u>   |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>MULTIPLE FRACTURES &amp; LACERATIONS</u> |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 20a. ACCIDENT <input checked="" 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.)<br><u>CAR ACCIDENT</u> |
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| 20c. TIME OF INJURY .Hour <u>5:50</u> Month <u>8</u> Day <u>25</u> Year <u>58</u> <u>p.m.</u> | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION <u>019</u> COUNTY STATE |
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| 21. I attended the deceased from _____, to _____, and last saw her/him alive on _____<br>Death occurred at <u>5:50</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated. |
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|   |                                       |                                 |
|---|---------------------------------------|---------------------------------|
| 22a. SIGNATURE <u>Neal Jander</u> (Degree or title) <u>Cross Cass Co. 3</u> | 22b. ADDRESS <u>Pleasant Hill, Mo</u> | 22c. DATE SIGNED <u>8/27/58</u> |
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| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) | 23b. DATE <u>Aug. 30 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Clayton Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Clayton New Mexico</u> |
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| 24. FUNERAL DIRECTOR <u>Burmenbuycis Harrisonville Mo</u> ADDRESS | 25. DATE RECD BY LOCAL REG. <u>Aug 27 1958</u> | 26. REGISTRAR'S SIGNATURE <u>Dora Barwood</u> |
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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

300  
1-57

57

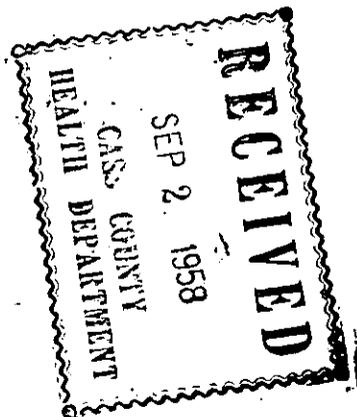
SEP 17 1958

SEP 17 1958

FEB 18 1959

VS AUG 14 1959

MAY 26 1959



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 R. Phillips* .....

Licensed Embalmer No. *4641* .....

P. O. Address *Harrisonville* .....

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.