

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044197  
STATE FILE NUMBER

73519-58  
FILED JAN 5 1958

Registration District No. 149 Primary Registration District No. 1009 Registrar's No. 5945

300  
1-57

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Jackson</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>Kansas City</b>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY<br>OR<br>TOWN <b>Blue Springs</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                         |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>3319 College</b>  |                                  | Length of stay in lb<br><b>3 days</b>   | STREET ADDRESS<br><b>Route # 2</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                        |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>RONALD DWAYNE JONES</b>  |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Dec. 15 1958</b>  |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 20, 1958</b>  |  | 9. AGE (In years last birthday)<br><b>2</b> MONTHS <b>25</b> DAYS <b>5</b> HOURS <b>1</b> MIN.    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Child</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Child</b>   |  | 11. BIRTHPLACE (City and state or country)<br><b>Kansas City, Mo.</b>    |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                  |   | 13a. FATHER'S NAME<br><b>Lee Earl Jones</b>  |  |   |
| 13b. MOTHER'S MAIDEN NAME<br><b>Rosemary Forth</b>   |                                  |   | 14. NAME OF HUSBAND OR WIFE<br><b>None</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br>Address<br><b>Mr. Lee Earl Jones, Blue Springs, Mo.</b> |   |
| 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) <b>Bronchial Pneumonia</b>  |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Suppurative Meningitis (non-Epidemic)</b>   |                                  |   |  |  |   |
| DUE TO (c) <b>Influenza Virus</b> 3400   |                                  |   |  |  |   |
| 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?<br>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<br>Hour Month, Day, Year<br>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 COUNTY STATE                                |   |
| 21. I attended the deceased from <b>12-12-58</b> to <b>12-15-58</b> and last saw her alive on <b>12-12-58</b><br>Death occurred at <b>5:30 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |  |   |
| 22a. SIGNATURE<br><b>J. M. Haight</b> (Degree or title)  |                                  |   | 22b. ADDRESS<br><b>3401 E. 12th K.C. Mo</b>  |  | 22c. DATE SIGNED<br><b>12-15-58</b>   |
| 23a. BURIAL CREMATION, (Specify)   |                                  | 23b. DATE<br><b>12-16-58</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harting Cemetery</b>            |   |
| 23d. LOCATION (City, town, or county) (State)<br><b>Warsaw, Missouri</b>   |                                  | 24. FUNERAL DIRECTOR ADDRESS<br><b>Mellody-McGilley-Eylar Funeral Home</b>  |  |  |   |
| 25. DATE RECD. BY LOCAL REG.<br><b>12-16-58</b>  |                                  | 26. REGISTRAR'S SIGNATURE<br><b>neva minshall</b>   |  |  |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

J. M. Haight

Woodland-Linwood

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

*Handwritten notes:*  
3451E 12

*Handwritten:* B. 1-4823

*Handwritten:* 3-6 PM

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 *Melvin Barton* .....

Licensed Embalmer No. *4903* .....  
P. O. Address *K. L. 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.