

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005633

STATE FILE NUMBER

FILED FEB 17 1959 Registration District No. 149 Primary Registration District No. 1022 Registrar's No. 420

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| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>                 |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>Roeland Park</b> <span style="float: right;">2150</span>           |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St Lukes Hospital</b> |  | Length of stay in lb<br><b>1 yr.</b>   | d. STREET ADDRESS (If outside, give location)<br><b>5036 Clark Drive</b>              |
|   |  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED<br>(Type or print)                  |  |  | 4. DATE OF DEATH                                 |  |  |  |
| First <b>Lula</b> Middle <b>James</b> Last <b>James</b> |  |  | Month <b>Jan.</b> Day <b>22</b> Year <b>1959</b> |  |  |  |

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|-------------------------|----------------------------------|---|---|--|--|--|
| 5. SEX<br><b>Female</b> | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 5, 1863</b> | 9. AGE (In years last birthday)<br><b>95</b> | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At Home</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br><b>St Louis Mo.</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
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| 13a. FATHER'S NAME<br><b>William Doran</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Lucy Danials</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Dr. Samuel C. Jones</b> |
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| 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><b>Mrs. W.G. Sparks</b> Address <b>5036 Clark Dr.</b> |
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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><i>Pneumonia and Pulmonary Edema</i></u> |                      | INTERVAL BETWEEN ONSET AND DEATH<br><u><i>2 days</i></u>                               |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) <u><i>Generalized Arteriosclerosis</i></u>                        | <u><i>years.</i></u> |  |
| 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 type="checkbox"/> NO <input 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<br>Hour <b>0</b> Month, Day, Year <b>01-22-59</b><br>a.m. <b>0</b> p.m. <b>0</b> | 20d. INJURY OCCURRED WHILE AT WORK <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<br><b>Bunceton</b> | COUNTY<br><b>Mo.</b> | STATE<br><b>Mo.</b> |
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| 21. I attended the deceased from <u><i>51</i></u> , to <u><i>1-21-59</i></u> and last saw her alive on <u><i>1-21-59</i></u><br>Death occurred at <u><i>7 am</i></u> <u><i>1-22-59</i></u> m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE<br><i>John A. Griffith M.D.</i> (Degree or title) | 22b. ADDRESS<br><b>315 Nichols Rd. K.C. Mo</b> | 22c. DATE SIGNED<br><b>1/23/59</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>1/25/59</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bunceton Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Bunceton Mo.</b> |
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| 24. FUNERAL DIRECTOR<br><b>Stine &amp; McClure</b> ADDRESS <b>K.C. Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>1-23-59</b> | 26. REGISTRAR'S SIGNATURE<br><i>Neve Marshall</i> |
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John A. Griffith M.D. must be causally related. MEDICAL CERTIFICATION

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 *J. S. Walton* .....

Licensed Embalmer No. *2744* .....

P. O. Address *K. C. Md* .....

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.