Health, Welfare Public Service

300 9
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005650
STATE FILE NUMBER

FILED FEB 19 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 579

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: St. Mary's Hospital — Length of stay in 1b: non Resident

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ill.
b. COUNTY: Knox
c. CITY OR TOWN: Galesburg City — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1470 N. West St. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: JOHN Middle: T. Last: JONES

4. DATE OF DEATH: Month Jan. Day 29 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: July 1884
9. AGE (In years last birthday): 74 — 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): Ret. - Sales
10b. KIND OF BUSINESS OR INDUSTRY: Wholesale Hardware
11. BIRTHPLACE (City and state or country): Goreville, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: John Jones
13b. MOTHER'S MAIDEN NAME: (Unknown) Gore
14. NAME OF HUSBAND OR WIFE: Gertrude

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Paul Jones Address: 107 Davis Ave - White Plains, N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
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 _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Hugh H. Owens Coroner
22b. ADDRESS: 1034 Realty Bldg.
22c. DATE SIGNED: 1-30-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1-31-59
23c. NAME OF CEMETERY OR CREMATORY: —
23d. LOCATION (City, town, or county) (State): Galesburg, Ill.

24. FUNERAL DIRECTOR: Mellody-McGilley-Eylar ADDRESS: 1800 Linwood
25. DATE RECD. BY LOCAL REG.: 1-30-59
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

Hugh H. Owens

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, Coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be accepted. All diseases in Part I must be causally related.

FEB 19 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 George A. Jack

Licensed Embalmer No. 5029

P. O. Address K. C. 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.