

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017785

STATE FILE NUMBER

2178

8
FILED MAY 29 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osteopathic Hospital		d. STREET ADDRESS (If outside, give location) 104 W. 9th. St.	
3. NAME OF DECEASED (Type or print) First Middle Last Dora A. Jones		4. DATE OF DEATH Month Day Year April 30, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Missouri
13a. FATHER'S NAME Elma Meeker		13b. MOTHER'S MAIDEN NAME Louisa Chrisman	14. NAME OF HUSBAND OR WIFE Harvey A. Jones
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 491-20-66511	17. INFORMANT Address Mrs. Anna Lee West Box 845 Blue Diamond Nevada
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial B. Natural Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) Post Surgery - malnutrition DUE TO (c) Electrolytic and Water Imbalance PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 days 7 wks - 2 years
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 Hour Month, Day, Year a.m. p.m.			
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 COUNTY STATE
21. I attended the deceased from April 12, 1959 to April 30, 1959 and last saw her alive on April 30, 1959 Death occurred at 8:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Sherrill H. Frye M.D.		22b. ADDRESS 3333 Jackson L.C. Mo.	22c. DATE SIGNED 4-30-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23c. NAME OF CEMETERY OR CREMATORY -	23d. LOCATION (City, town, or county) (State) Chillicothe Mo.
24. FUNERAL DIRECTOR Stine & McClure		25. DATE RECD. BY LOCAL REG. 5-1-59	26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

Sherrill H. Frye USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

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.

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NOV 12 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 *Elmer D. Zippert*

Licensed Embalmer No. 4817.....

P. O. Address *Kansas City, 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.