

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039015

FILED VS DEC 14 1959

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <b>Buchanan</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>Platte</b>		
Length of stay in lb <b>5 years</b>		c. CITY OR TOWN <b>Weston</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>State Hosp. #2</b>		
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hosp. #2</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			Month Day Year		
First Middle Last <b>ARCH A. JONES</b>			<b>Dec. 5, 1959</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10-18-83</b>		
9. AGE (last birthday) <b>76</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		11. BIRTHPLACE (City and state or country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Frank Jones</b>			13b. MOTHER'S MAIDEN NAME <b>Sarah Drake</b>			14. NAME OF HUSBAND OR WIFE <b>Lela Maud Jones</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>State Hosp. #2 records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b>							<b>2 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) _____								
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input 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 Hour a.m. p.m.		Month, Day, Year						
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 <b>Dec. 3, 1959</b> to <b>Dec. 5, 1959</b> and last saw her/him alive on <b>Dec. 4, 1959</b> Death occurred at <b>6:35 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>R.P. Price M.D.</b>				22b. ADDRESS <b>State Hosp. #2 St. Joseph Mo</b>		22c. DATE SIGNED <b>12 5 59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-7-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Graveland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Weston, Missouri</b>			
24. FUNERAL DIRECTOR <b>Vaughn Funeral Home Weston, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Dec. 7, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Lindell</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 W. R. Vaughn

Licensed Embalmer No. 4023

P. O. Address Weston, N.C.

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.