URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 17 1959

59-040147

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5312

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City
Length of stay in 1b: 2 1/2 Hrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St Mary,s Hosp
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: Jackson
c. CITY OR TOWN: Blue Springs
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS: 707 (If outside, give location): SUMMIT
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Claude Middle: Allen Last: Jones
4. DATE OF DEATH: Month: Nov Day: 1 Year: 1959
5. SEX: Male
6. COLOR OR RACE: Wh
7. Married [ ] Never Married [X] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: Nov 1 1959
9. AGE (last birthday): IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HR: Hours: 2 Min.: 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Kansas City Mo
12. CITIZEN OF WHAT COUNTRY: usa
13a. FATHER'S NAME: Galen Jones
13b. MOTHER'S MAIDEN NAME: Audry Chiddix
14. NAME OF HUSBAND OR WIFE: -
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Galen Jones Address: 707 Summit Blue Springs Mo

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): Intrastitial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Premature rupture of fetal membranes — ?
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. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]
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 11/1/59, to 11/1/59 and last saw him alive on 11/1/59
Death occurred at 7 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: O J Leitch (Degree or title): M D
22b. ADDRESS: 808 Sw 15 Blue Springs Mo
22c. DATE SIGNED: 11/6/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Nov 4 1959
23c. NAME OF CEMETERY OR CREMATORY: Blue Springs Cem
23d. LOCATION (City, town, or county) (State): Blue Springs Mo

24. FUNERAL DIRECTOR ADDRESS: Webb Funeral Home Blue Springs Mo
25. DATE RECD. BY LOCAL REG.: 11-4-59
26. REGISTRAR'S SIGNATURE: Neva Mitchell

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF O. J. Leitch

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

~~or by~~ —, Student Embalmer No. —

working under my personal supervision.

Student —
Signature of Student Embalmer

Signed William Fre

Licensed Embalmer No. 4733

P. O. Address Blue Springs

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.