URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 10 1959

59-040150
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5789

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: 46 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST LUKES Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: JACKSON
c. CITY OR TOWN: KANSAS City — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 6233 Walrond — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: SIMPSON Middle: E. Last: JONES
4. DATE OF DEATH: Month 11 Day 29 Year 1959
5. SEX: M
6. COLOR OR RACE: W
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: June 23 1894
9. AGE (last birthday): 65 — 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): MAINTENANCE ENGINEER
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (City and state or country): STATE CENTER IOWA
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: HOMER JONES
13b. MOTHER'S MAIDEN NAME: LULA RHOADES
14. NAME OF HUSBAND OR WIFE: CORA B. JONES
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.: 486 07 5910
17. INFORMANT: CORA JONES Address: 6233 WALROND K.C. 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): Possible Post-Operative Pulmonary Embolism
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Total Aptectomy 11-24-59 for Bladder
DUE TO (c): CARCINOMA
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)
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 11-17-1959, to 11-29-1959 and last saw ~~her~~ him alive on 11-28-1959
Death occurred at 5:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: George O. Miles (Degree or title): M.D.
22b. ADDRESS: 4706 Bldwy KC Mo
22c. DATE SIGNED: 11-30-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: DEC 1-1959
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Mt Moriah Cemetery
23d. LOCATION (City, town, or county) (State): K.C. Mo.

24. FUNERAL DIRECTOR: Floral Hills Memorial Chapel ADDRESS: K.C. Mo.
25. DATE RECD. BY LOCAL REG.: 12-1-59
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF: O. Miles

DOCUMENT

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_____ Signed Forest D. Coldsmou

Signature of Student Embalmer

Licensed Embalmer No. 4714

P. O. Address K.C. Mo.

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.