

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-002032

FILED 15 JAN 26 1960

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 54

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>JACKSON</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>INDEPENDENCE</u>		c. CITY OR TOWN <u>INDEPENDENCE</u>		d. STREET ADDRESS (If outside, give location) <u>1913 Maywood</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>INDEPENDENCE</u>		Length of stay in lb <u>15 yrs</u>		c. CITY OR TOWN <u>INDEPENDENCE</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1913 Maywood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1913 Maywood</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>JAMES</u>		Middle <u>MACK</u>		Last <u>JONES</u>		Month <u>Jan</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-85</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Keith Furniture</u>		11. BIRTHPLACE (City and state or country) <u>Clinton Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>unknown</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Faye Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>486-09-3059</u>		17. INFORMANT <u>FAYE JONES</u> Address <u>1913 Maywood</u>			
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) <u>Coronary occlusion</u>						<u>72 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>						<u>2 year</u>	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>nasal carcinoma of the nose</u>						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 checked="" 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 <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u></u>					
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 <u>Jan 11, 1960</u> to <u>Jan 20, 1960</u> and last saw her/him alive on <u>Jan 20, 1960</u>				Death occurred at <u>7:30p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>B H Boyd J DO</u> (Degree or title)				22b. ADDRESS <u>9529 TRUMAN RD INDEP MO</u>		22c. DATE SIGNED <u>1/22/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>1-23-60</u>	23c. NAME OF CEMETERY OR CREMATOR <u>MEMORY GARDENS</u>		23d. LOCATION (City, town, or county) <u>Richmond Mo</u> (State)		
24. FUNERAL DIRECTOR <u>Robert R. Speaks</u> ADDRESS <u>INDEP. MO</u>			25. DATE RECD. BY LOCAL REG. <u>1-23-60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Rollie Fessel

Licensed Embalmer No. 4690

P. O. Address Indep. W.

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.