

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005218

FILED VS MAR 7 1960 042

Registration District No. _____ Primary Registration District No. **1000** Registrar's No. **247**

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 17 days		c. CITY OR TOWN Agency		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hospital			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) First ROBERT Middle LEE Last JONES			4. DATE OF DEATH Month February Day 26 Year 1960				
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/12/1886	9. AGE (last birthday) 73	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) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (City and state or country) Agency, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Harvey Jones			13b. MOTHER'S MAIDEN NAME Mary Auxier		14. NAME OF HUSBAND OR WIFE Nola E. 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. 494-14-3398	17. INFORMANT Address Mrs. Robert Jones, Agency, Missouri			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with Myocardial Infarct and Ventricular Aneurysm DUE TO (b) Coronary Sclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)						INTERVAL BETWEEN ONSET AND DEATH 2 months unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) General Anaesthesia for Orchiectomy					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 checked="" 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 Feb. 9, 1960 to Feb. 26, 1960 and last saw him xxx alive on Feb. 26, 1960 Death occurred at 11:30 a. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Allen J. Herman M.D.			22b. ADDRESS 706 Francis St. Joseph, Mo		22c. DATE SIGNED 2-29-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 2/28/1960	23c. NAME OF CEMETERY OR CREMATORY Agency Cemetery		23d. LOCATION (City, town, or county) (State) Agency Missouri			
24. FUNERAL DIRECTOR Wheaton Bowman		ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Mar. 2, 1960	26. REGISTRAR'S SIGNATURE Mr. Clark Goodell		

DOCUMENT

CERTIFICATION

A. E. Herman, M.D.

BY AFFIDAVIT OF

Dr. Kie:

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 William Spalding

Licensed Embalmer No. 4535

P. O. Address St Joseph 9

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.