

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=60-018441**

FILED VS JUN 13 1960

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STATE FILE NUMBER

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

NDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Buchanan</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>7 days</u>		c. CITY OR TOWN <u>Concord Twp.</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>No. Methodist Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R. F. D. Plattsburg, Mo.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>Allen</u> Last <u>Jones</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>29</u> Year <u>1960</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-27-1882</u>	<b>9. AGE (last birthday)</b> <u>77</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or county) <u>Plattsburg, Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>John M. Jones</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Virginia Shoemaker</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>Susan Jones</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>497-40-0443</u>		<b>17. INFORMANT</b> <u>Mrs. C. G. Jones</u>			Address <u>Plattsburg, Mo</u>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of left kidney</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>6 month</u>	
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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)						
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____								
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY _____ STATE _____		
<b>21. I attended the deceased from</b> <u>3/15/60</u> to <u>5/29/60</u> and last saw <sup>her</sup> him alive on <u>5/29/60</u> Death occurred at <u>5/29/60</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <u>Berbert P. Warren M.D.</u>				<b>22b. ADDRESS</b> <u>St. Joseph, Mo</u>		<b>22c. DATE SIGNED</b> <u>5/30/60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>6-1-1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenlawn</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Plattsburg, Mo</u>				
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Clyon Funeral Home inc. Plattsburg, Mo.</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>June 1, 1960</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Mr. Clark Goodell</u>			

DOCUMENT

MEDICAL CERTIFICATION  
H.L. Warren, M.D.

BY AFFIDAVIT OF

OCT 8 1964

JUN 14

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 Phillip E. Cox

Licensed Embalmer No. 4993

P. O. Address Clarksburg, W. Va.

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.