

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025816

FILED VS JUL 25 1960

38

Registration District No. Primary Registration District No. 3006 Registrar's No. 414

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo.</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>59 Days</u>	c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR UNIVERSITY OF MO. <u>medical center</u> INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside give location) <u>904 Prospect</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>DALE</u> Middle <u>ALBERT</u> Last <u>JONES</u>			4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-59</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>9</u> Days <u>4</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Joseph Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>LEONARD JONES</u>		13b. MOTHER'S MAIDEN NAME <u>JOAN SILCOTT</u>		14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>University of Mo. Medical Records</u> Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>pulmonary hypertension</u>	
	DUE TO (c) <u>ventricular septal defect</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pt. had thoracotomy on 17 July.</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	
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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 <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 4 July '60 to 19 July '60 and last saw <sup>her</sup>him alive on 19 July 60  
Death occurred at 11:50 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J. R. Ellis M.D.</u>		22b. ADDRESS <u>O. of Mo. Medical Center</u>		22c. DATE SIGNED <u>20 July '60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>July 20-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Amazonia Cem</u>	23d. LOCATION (City, town, or county) <u>Amazonia MO.</u>	
24. FUNERAL DIRECTOR <u>Parsons Funeral Service</u> <u>Columbia Mo.</u> (Licensed Embalmer)		25. DATE RECD. BY LOCAL REG. <u>July 20 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</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 George A. Kerby

Licensed Embalmer No. 4733

P.O. Address Columbia, Mo.

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.