

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-041117**

ED VS DEC 5 1960  
DED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1240

STATE FILE NUMBER

|  |   |   |  |   |  |   |  |       |
|--|---|---|--|---|--|---|--|-------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Kansas</b> b. COUNTY <b>Doniphan</b> |  |   |  |       |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Joseph</b>   |   | Length of stay in 1b<br><b>3 days</b>   |  | c. CITY OR TOWN <b>Highland</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |       |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Josephs Hospital</b>   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)                          |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>A.</b> Last <b>JONES</b>  |   |   |  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>26</b> Year <b>1960</b>  |  |   |  |       |
| 5. SEX <b>male</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10/29/1874</b>   | 9. AGE (last birthday)<br><b>86</b>                                    | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HR<br>Hours Min.   |       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired teacher &amp; farmer</b>   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (City and state or country)<br><b>Franklin, Indiana</b> |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |       |
| 13a. FATHER'S NAME<br><b>Frank Jones</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Harriet Woodside</b>                                 |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Minnie M. Jones</b>                     |  |       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   |   | 16. SOCIAL SECURITY NO.<br><b>515-40-1635</b>  |   | 17. INFORMANT Address<br><b>Miss Jane Jones, Highland, Kansas</b>      |   |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |   |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |       |
| IMMEDIATE CAUSE (a) <b>Acc. left route under failure</b>   |   |   |  |   |  |   | <b>1/2 hr</b>  |       |
| DUE TO (b) <b>Patience related heart disease</b>   |   |   |  |   |  |   | <b>unknown</b>   |       |
| DUE TO (c)   |   |   |  |   |  |   |  |       |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |       |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>a.m. p.m.  |   |   |  |   |  |   |  |       |
| 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 <b>1958</b> to <b>Nov 26, 1960</b> and last saw <sup>her</sup> him alive on <b>Nov 26, 1960</b><br>Death occurred at <b>10:00 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |   |  |   |  |       |
| 22a. SIGNATURE (Degree or title)<br><b>William A. Ames, MD</b>   |   |   |  | 22b. ADDRESS<br><b>902 Edmund St</b>  |  | 22c. DATE SIGNED<br><b>11-30-60</b>                                       |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>  |   | 23b. DATE<br><b>11/26/1960</b>  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City, town, or county)<br><b>Highland Kansas</b>        |   | (State)  |       |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Heaton-Bowman, St. Joseph, Mo.</b>  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>Dec. 2, 1960</b>                                  |   | 26. REGISTRAR'S SIGNATURE<br><b>Wm. Clark Goodell</b>                  |   |  |       |

DOCUMENT

MEDICAL CERTIFICATION  
W. H. Ames, M.D.

BY AFFIDAVIT OF

DEC 20 1960

**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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 314 50/10th St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.