

# RI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048748

FILED VS JAN 24 1961

149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 6507

STATE FILE NUMBER

INDEXED

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>Kansas City</u>		a. STATE <u>Missouri</u> COUNTY <u>Johnson</u>		c. CITY OR TOWN <u>Kingsville</u>	
Length of stay in lb <u>60 days</u>		c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VA Hospital, K, C, Mo</u>		d. STREET ADDRESS (If outside, give location) <u>RR # 1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>WILLIAM</u>		Middle <u>ROBERT</u>		Last <u>JONES</u>		Month <u>December</u> Day <u>24</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>12 1 00</u>	9. AGE (last birthday) <u>60</u>		IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Adrian, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>	
13a. FATHER'S NAME <u>James Jones</u>			13b. MOTHER'S MAIDEN NAME <u>Emma</u>			14. NAME OF HUSBAND OR WIFE <u>K. Lillie Ann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>495 07 6792</u>		17. INFORMANT Address <u>K. Lillie Ann Jones Kingsville, Mo.</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>Adenocarcinoma of right parotid with metastases generalized.</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (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. <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 _____ a.m. _____ p.m.	Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> VA NOT WHILE AT WORK <input checked="" 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>October 25, 1960</u> to <u>Dec. 24, 1960</u> Death occurred at <u>6:22 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. M. ZIMMERMAN, M.D.</u>				22b. ADDRESS <u>VA Hospital, Kansas City, Mo.</u>		22c. DATE SIGNED <u>12/24/60</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12 27 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>			
24. FUNERAL DIRECTOR <u>Floral Hills Memorial Chapels, Inc</u>		ADDRESS <u>K. C. Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12.27.60</u>	26. REGISTRAR'S SIGNATURE <u>H-L-Dwyer</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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Forrest D. Caldwell

Licensed Embalmer No. 471

P. O. Address K.C. Mo.

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