

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032932

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 4490

FILED SEP 25 1961

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		Length of stay in 1b 3 MONTHS 31 DAYS	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A. HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) APT. # 203 2730 TROOST AVENUE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JOHN Middle EDWARD Last JONES			4. DATE OF DEATH Month September Day 8 Year 1961	
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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"/> Separated	8. DATE OF BIRTH 11-18-28	9. AGE (last birthday) 32	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Forestburg, S. Dak.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John Jones	13b. MOTHER'S MAIDEN NAME Nellie Williams	14. NAME OF HUSBAND OR WIFE MRS. CREDELL JONES
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes	16. SOCIAL SECURITY NO. WWIT	17. INFORMANT VA Hospital Official Records, Kansas City
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins disease		INTERVAL BETWEEN ONSET AND DEATH
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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 VA	COUNTY	STATE
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21. I attended the deceased from **July 5, 1961** to **Sept. 8, 1961**
Death occurred at **5:30 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert W. Brown (Degree or title)	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 9-8-61
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23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE SEPT. 11, '61	23c. NAME OF CEMETERY OR CREMATORY MAPLE HILL CEMETERY	23d. LOCATION (City, town, or county) KANSAS CITY KANSAS
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24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS KANSAS CITY, MO.	ADDRESS 1331 BRUSH CR.	25. DATE RECD. BY LOCAL REG. 9-9-61	26. REGISTRAR'S SIGNATURE Ruth Long
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

NOV 17 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signature *Harold B. Esterna*

Licensed Embalmer No. 9035
P. O. Address *H. B. Esterna*

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.