

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043889  
STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. \_\_\_\_\_ Registrar's No. 216

**FILED JAN 4 1962**

1. PLACE OF DEATH a. COUNTY <u>CASS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CASS</u>				
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>BELTON, MO.</u>		Length of stay in 1b <u>44 yrs</u>	c. CITY OR TOWN <u>BELTON, MO.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>401 WALNUT</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>401 WALNUT</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JANE</u> Last <u>JONES</u>			4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1961</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1/8/1885</u>	9. AGE (last birthday) <u>76</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>PECULIAR, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>MARTIN KNIGHT</u>		13b. MOTHER'S MAIDEN NAME <u>SUSAN SEBAN</u>		14. NAME OF HUSBAND OR WIFE <u>R.E. JONES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>ROBERT JONES 1100 MAIN, BELTON, MO.</u>				
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>Medullary Paralysis</u> DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>arterio-sclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>hypertensive heart disease</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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"/> 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 <u>10:40</u> <u>1955</u> to <u>25 Dec. 1961</u> and last saw her alive on <u>12-25-61</u> Death occurred at <u>10:40</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>John B. Miller M.D.</u>				22b. ADDRESS <u>Belton Mo</u>		22c. DATE SIGNED <u>12/26/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>12/28/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BELTON CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BELTON MO</u>		
24. FUNERAL DIRECTOR ADDRESS <u>E.K. GEORGE &amp; SONS BELTON, MO.</u>			25. DATE RECD. BY LOCAL REG. <u>Dec, 29, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Per. Ray J. Seibel</u>			

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 4 1962

**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

Signed

*Jimmy S. Huchison*

Licensed Embalmer No. 4092

P. O. Address Bella, 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.