MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

24275

1. PLACE OF DEATH
County: Jackson
Township: Kaw
City: Kansas City Mo (No. Old City Hos. St. Ward)
Registration District No. 399
Primary Registration District No. 1002
File No. 5002
Registered No.

2. FULL NAME: Enoch Jones
(a) Residence. No. County House St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Wid. 13 yrs.

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF DATH (MONTH, DAY AND YEAR): Unknown

7. AGE: Years 53 | Months — | Days — | If LESS than 1 day, ...hrs. or ...min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kansas

PARENTS
10. NAME OF FATHER: Mr. Jones
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Kansas
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Kansas

14. INFORMANT: Mrs. Jones
(Address): 1404 Garfield

15. FILED: 8/5, 19 27 M. M. Crowe Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 8-4-1927

17. I HEREBY CERTIFY, That I attended deceased from 8-2-, 1927 to 8-4-, 1927 that I last saw h. i. m. alive on 8-4-, 1927, and that death occurred, on the date stated above, at 5:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Stricture of Rect. Prolapse of Rect (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no. DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) H. M. Smith. M. D
8/5, 19 27 (Address) Old City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Blue Ridge | DATE OF BURIAL: 8-6-1927

20. UNDERTAKER: H. B. Moore | ADDRESS: 1820 88

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.