

DEC 20 1928

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

Do not use this space.

36177

1. PLACE OF DEATH

County... Buchanan
Township... Joseph
City... Division

Registration District No. 85
Primary Registration District No. 1001

File No. _____
Registered No. 1366
St. _____ Ward _____

2. FULL NAME

Leon L. Jones
(a) Residence. No. 231 Iowa Ave. St. _____
(Usual place of abode)

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 Male
4. COLOR OR RACE Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 5 - 1907

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
21 9 24

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butcher (opt)
(b) General nature of industry, business, or establishment in which employed (or employer) " "
(c) Name of employer Swift & Co.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Joseph Mo.

10. NAME OF FATHER Richard H. Jones

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Buchanan Mo.

12. MAIDEN NAME OF MOTHER Maggie Shilton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Buchanan Mo.

14. INFORMANT Richard H. Jones
(Address) 231 Iowa Ave.

15. FILED 1928
John J. [Signature] REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/29 1928

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
that I last saw him/her alive on _____ 19____, and that death occurred, on the date stated above, at _____ A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhage as a result of a stab wound in neck, severing carotid (Homicidal) (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 198 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) J. P. [Signature] M. D.
(Address) St. Joseph Mo.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL King Hill Cemetery DATE OF BURIAL 12/3/1928

20. UNDERTAKER Rausser Funeral Service ADDRESS Pk. & Olive

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.

