

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

Do not use this space.

40663

File No. 5000
Registered No. 5000
St. _____ Ward _____

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township 1st Kaw Primary Registration District No. _____
City Kansas City, Mo. No. Wesley Hospital

2. FULL NAME

Louis Ann Jones
(a) Residence. No. Wesley Hospital 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-7-1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 10 hrs. or 10 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City, Mo.
(STATE OR COUNTRY) Wesley Hosp

10. NAME OF FATHER E. G. Jones

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kansas City, Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mildred L. Coates

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

14. INFORMANT Elmer Jones
(Address) 6624 India

15. FILED 17/9 19 29 M. M. Crowe
REGISTRAR -ass

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 8 19 29

17. I HEREBY CERTIFY, That I attended deceased from 12/7, 1929, to 12/8, 1929, that I last saw her alive on 12-8, 1929, and that death occurred, on the date stated above, at 2 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

821 Central hemorrhage

CONTRIBUTORY (SECONDARY)

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 Clinical findings

12 (Signed) Ralph King, M. D.

18, 1929 (Address) 1111 Grand

*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 Elmwood DATE OF BURIAL Dec 9 19 29

20. UNDERTAKER J. O. Wagner ADDRESS 1409 Grand

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.

