

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

Do not use this space.

12770

1. PLACE OF DEATH

County Jackson Registration District No. 332
 Township Raw Primary Registration District No. 1002
 City Kansas City (No. St Anthony Home)

File No. 1038
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME Justin Matthew Jones

(a) Residence No. St. Anthony's H. 237 St. Collegeville Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. 16 ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>3-27-30</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
			<u>18</u>	

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) _____

(c) Name of employer _____

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

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) not known

12. MAIDEN NAME OF MOTHER Mattie Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) not known

14. INFORMANT Sister M. Joseph
 (Address) St. Anthony's Home

15. FILED 4/18/30 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 15 1930

17. I HEREBY CERTIFY That I attended deceased from 3-27-30, 1930 to 4-15-30, 1930 that I last saw him alive on 4/15/30, 1930, and that death occurred, on the date stated above, at 11:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intoxication
1128
136 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Allo-Calitis
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 1130
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Physic
 (Signed) Joseph M. White, M. D.
4/16, 1930 (Address) 1915 Maple

*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 St Marys Cemetery DATE OF BURIAL April 18 1930

20. UNDERTAKER John W Wagner ADDRESS 1409 Grand

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

MAINTAINED FOR BINDING

