

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

Do not use this space.

22750

2738

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_

Township Kaw Primary Registration District No. \_\_\_\_\_

City K. C. Mo. (No. 3938 Cases) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

**2. FULL NAME Bobby Byaird Jones**

(a) Residence No. 3938 Paces St. \_\_\_\_\_ Ward \_\_\_\_\_ (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 wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2/4/23 (1)

7. AGE YEARS 7 MONTHS 4 DAYS 28 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work child  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) K. C. Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Mason R. Jones

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

12. MAIDEN NAME OF MOTHER Annie Woods

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Smithville  
(STATE OR COUNTRY) mo

14. INFORMANT Mason Robert Jones  
(Address) 3931 Paces

15. FILED 7/8 1930 M. M. Craue REGISTRAR  
aact.

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/2 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 22, 1923, to July 2, 1930, that I last saw him alive on July 2, 1930, and that death occurred, on the date stated above, at 4 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

8 Scarlet fever  
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
(Signed) Edwin Hey Silver, M. D.

July 5, 1930 (Address) 922 Platte Hwy, Kansas City, Mo.

\*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 Smithville Mo DATE OF BURIAL 7/3 1930

20. UNDERTAKER Morton & Co ADDRESS N. K. C.

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.

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

