

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.

16-25

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

Do not use this space.

16713

**1. PLACE OF DEATH**

County Jackson Registration District No. 389  
 Township Caw Primary Registration District No. 5002  
 City Kansas City, Mo. No. St. Marys Hospital

File No. 2210  
 Registered No. 2210  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Chris L. Jones  
 403 Jackson St. Osage City, Kas. St. \_\_\_\_\_ Ward \_\_\_\_\_

(a) Residence, No. \_\_\_\_\_ (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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Married</u>		6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>April 1889</u>		
7. AGE YEARS <u>44</u>	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Do not know</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>✓</u>			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>				
MOTHER / FATHER	13. NAME <u>Unknown</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>			
	15. MAIDEN NAME <u>Unknown</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>			
17. INFORMANT <u>Dr. J. C. Castle</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Osage City, Kas.</u> DATE <u>5/27</u> 19 <u>33</u>				
19. UNDERTAKER <u>St. Marys Funeral Home Inc</u> (ADDRESS) <u>3176 main St.</u>				
20. FILED <u>May 24, 1933</u> <u>M. M. Crowe</u> Registrar.				

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-24- 1933

22. I HEREBY CERTIFY, That I attended deceased from St. Marys Hospital, 1933  
 I last saw h. alive on \_\_\_\_\_, 1933. Death is said to have occurred on the date stated above, at 11:30 a. m.

The principal cause of death and related causes of importance were as follows:

Coronary Occlusion Date of onset \_\_\_\_\_  
Chronic Myocardial Infarction  
940  
940  
 Other contributory causes of importance:  
Acute Coronary Thrombosis  
Chronic Myocardial Infarction

Epi-thymic lymphadenitis Date of operation 5/29/33  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1933  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_ (Signed) [Signature] \_\_\_\_\_  
 (Address) [Address]

DEPCON X

