

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

9814  
Do not use this space.

1. RECEIVED APR 2 1938

(a) County Jackson Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. 330 North Topping St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 1279

2. PRINT FULL NAME Nannie Jones 520  
 (a) Residence, No. 330 North Topping St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John F. Jones

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 15, 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
76 8 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. At home  
 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) Kentucky

FATHER 13. NAME David Piratt

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No record

MOTHER 15. MAIDEN NAME Elizabeth Tipton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT L. R. Jones  
 (ADDRESS) 330 N. Topping, Kansas City, Mo

18. ~~BORER~~ ~~WORK~~ ~~ON~~ ~~OR~~ ~~REMOVAL~~  
 PLACE Jefferson City, Mo DATE 3/25 1938

19. FUNERAL DIRECTOR Stine & McClure  
 (ADDRESS) Kansas City, Mo.

20. FILED Mar 22 1938 M. M. Crown  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 21 1938

22. I HEREBY CERTIFY, That I attended deceased from Mar 15, 1938, to Mar 20, 1938

I last saw her alive on Mar 20, 1938. Death is said to have occurred on the date stated above, at P. 3:50 m.

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

Arterial Haemorrhage Cerebral Hemorrhage  
arterio sclerosis  
 Date of onset Mar 15 1938

Other contributory causes of importance: arterio sclerosis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 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? No  
 If so, specify \_\_\_\_\_  
 (Signed) A. A. Williams, M. D.  
 (Address) 2400 5th John Ave  
K. C. Mo

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.

1 X12004

---

---

**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No. ....  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....  
..... L. E. ....  
No.....or by....., Registered Apprentice No.....  
working under my personal supervision.  
Signed.....  
.....  
Licensed Embalmer No.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**