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.

REC'D MAY 10 1939

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

13731
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson
(b) Township Kaw
(c) City Kansas City
(d) Street No. General Hospital #2 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. 19 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 399
Primary Registration District No. 1002
Registered No. 1485

2. PRINT FULL NAME 521 Tommie Jones

(a) Residence, No. 1608 Garfield Apt 15 St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Tessie Jones

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Nov. 13 " '16

7. AGE: YEARS 22 | MONTHS 4 | DAYS 23 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Laborer
9. Industry or business in which work was done, as saw mill, bank, etc.: W. P. A.
10. Date deceased last worked at this occupation (month and year):
11. Total time (years) spent in this occupation: 4/4/39

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Oklahoma City, Ok.

FATHER
13. NAME: Tommie Jones
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Oklahoma

MOTHER
15. MAIDEN NAME: Elizabeth Clark
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Texas

17. INFORMANT (ADDRESS): Elizabeth Jones, 1608 Garfield Apt. 16

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Lincoln Cemetery DATE: April 9" '39

19. FUNERAL DIRECTOR (NAME) (ADDRESS): C. H. Countee, Kansas City.

20. FILED 4-7 1939 M. M. Crowe, asst. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-5-39, 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19..... Coron
I last saw h.... alive on ..... 3 ..., 19..... Death is said to have occurred on the date stated above, at 2 ... m.
The principal cause of death and related causes of importance were as follows:
Gun Shot wound of head
Shot by Police
173

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Shot by Police 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?
If so, specify
(Signed) Russell W. Kerr, M. D.
(Address) Hamo

(Licensed Embalmer's Statement on Reverse Side)

DEC 1 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed T. J. Harris, Sr.

Licensed Embalmer No. 3388

P. O. Address 1409 E 12th St

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

If this body is not embalmed, above space should be left blank.