

REC'D JUL 10 1939

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

21261
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002
 (c) City Kansas City (d) Street No. St. Joseph Hospital 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 50 yrs. mos. ds. (f) How long in U.S., if of foreign birth? 51 yrs. mos. ds.

2. PRINT FULL NAME Mrs. Annie H. Jones
 (a) Residence, No. 3102 Benton Boulev. rd 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Theo. S. Jones

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 9, 1868

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
|--------|-----------|----------|-----------|----------------------------------|
| | <u>71</u> | <u>1</u> | <u>11</u> | |

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) Wales 4

FATHER
 13. NAME Michael Hughes 4
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wales 4

MOTHER
 15. MAIDEN NAME Don't Know 4
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wales

17. INFORMANT (ADDRESS) Mrs. Ethel Brown
3102 Benton Blvd.

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill DATE 6-23-39 19.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Freeman Mortuary
104 W. 42nd St., K.C., Mo.

20. FILED June 23 1939 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-20-39 19

22. I HEREBY CERTIFY, That I attended deceased from 6/14/39, 19, to 6/21/39, 19.
 I last saw her alive on 6/21/39 19. Death is said to have occurred on the date stated above, at 11 a.m.
 The principal cause of death and related causes of importance were as follows:
Arterio-sclerosis
Myocarditis 92 WHO
 Date of onset 3

Other contributory causes of importance:
Ac. Heart Failure 1 hr

Name of operation None Date of None
 What test confirmed diagnosis? Chloroform 4.50
 (Specify if on autopsy?) 4.50

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?
 If so, specify: John Oelwie, M. D.
 (Signed) John Oelwie
 (Address) 730 Prof Bldg

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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.)

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

Handwritten:
Duffy
2-6-67
P.M.