DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29367

REC'D SEP 20 1939

Registration District No. 404

Primary Registration District No. 5558

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 8444 Wornell Road, K.C.Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 7348 Walnut Str., K.C.Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mamie Jones 5-20

3. (b) If veteran, name war No.

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife George H. Jones

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct (Month) 14 (Day) (Year)

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Indiana (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ---------

FATHER
12. Name Nathan Pearce
13. Birthplace Md. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Blocker,
15. Birthplace Penna. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Ernest L. Long.
(b) Address 7348 Walnut Str., K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1-39 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Mrs. C.L. Forster
(b) Address 918 Brooklyn Avenue, K.C.Mo.

19. (a) 9-9-39 (Date received local registrar) (b) Job R.V. Lindsey & Sons By Roscoe H. Keeler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 30 day 30 year 1939 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from Aug 20, 1939, to Aug 30, 1939 that I last saw her alive on Aug 24, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma Stomach	over 2 yrs
Due to	
Due to 4-6	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature S. W. Fair (M. D. ~~or other~~)
Address 404 1/2 W 75 K C Mo Date signed 8/30/39

(Licensed Embalmer's Statement on Reverse Side)

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 Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address K.C. mo.

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

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

29367
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Washington
(c) City
Registration District No. 404
Primary Registration District No. 2558
Registered No.
(d) Street No. , 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.

2. PRINT FULL NAME Mamie James
(a) Residence, No. 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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) W

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-14-1864

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75			

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.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 10-5-, 1939 Mrs Jos. T Brennan
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-30, 1939

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

	Date of onset
Carcinoma Stomach	

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? 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) S. N. Fair, M. D.
(Address) 404½ W 75 K.C. Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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