

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.

54
80

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

32795
Do not use this space.

REC'D OCT 10 1939

1. PLACE OF DEATH *Ra Fayette*

(a) County *Ra Fayette* Registration District No. *464*

(b) Township *Classa* Primary Registration District No. *4277* Registered No. *45*

(c) City *Classa* (d) Street No. *Classa, Mo.* St. _____

(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 *Mary E Jones*

(a) Residence, No. *1412 Prospect* St. *Kansas City, Mo.*
(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 (write the word) *Widowed*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 29 1863*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 yrs. 4/10 25

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *at Home*

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) *Indiana*

FATHER 13. NAME *Clark*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

MOTHER 15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *Mrs. Noah Ferguson 1412 Prospect, K.C.Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Memorial Park Cem.* DATE *Sept. 26th-32*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *C.H. Blackman & Son, Inc 2825 Indep. Blvd. K.C.Mo.*

20. FILED *Sept 25 1939 Mrs. E.M. Goodwin Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 24 1939*

22. I HEREBY CERTIFY, that I attended deceased from *July 20 1939* to *Sept 23 1939*

I last saw him alive on *Sept 23 1939*. Death is said to have occurred on the date stated above, at *6 p. m.*

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

Date of onset *12/4/38*

Other contributory causes of importance: *46*
Family

Name of operation _____ Date of _____

What test confirmed diagnosis? *Cholesterol* Was there an autopsy? *(initials)*

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? *(initials)*
If so, specify _____
(Signed) *R. O. Schooley, M. D.*
Classa, Mo. (Address)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10/5/39

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.