

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **27670**  
**3304**

399

1002

Registrar's No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4819 Jarboe 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution ---  
(Specify whether  
In this community 40 Years  
years, months or days)

3. (a) PRINT FULL NAME Mrs. Bessie Burleson Fones

3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mr. Kale M. Fones  
6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased April 3 1881  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
59 4 16 hr. min.

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

10. Usual occupation Housewife

11. Industry or business ---

MOTHER FATHER { 12. Name James Burleson

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

14. Maiden name Jane Brown

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

16. (a) Informant Mr. Kale M. Fones

(b) Address 4819 Jarboe

17. (a) Burial (b) Date thereof Aug. 22 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director D. H. Newcomer

(b) Address 1401 Brush Creek Blvd.

19. (a) Aug. 21, 1940 (b) M. McCreary  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4819 Jarboe Street  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? --- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19th  
year 1940 hour 6 minute 20 P. M.

21. I hereby certify that I attended the deceased from June 1940 to 8-19 1940  
that I last saw him alive on 6-19 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral spread of abs.  
Due to Cerebral Syphilis

Due to 46

Other conditions: ---  
(Include pregnancy within 3 months of death)

Major findings: Cerebral Syphilis  
Of operations ---

Of autopsy ---

Duration

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) (e) Means of injury ---

23. Signature D. H. Newcomer (M. D. or other)  
Address 924 1/2 N. 1st St. Date signed 8/20/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 *C. Hervey Quisenberry*

Licensed Embalmer No. *4070*

P. O. Address *A. C. Mo*

**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.**