

3-40
-39
X23159

Registration District No. **399**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kansas City Mo**

(c) Name of hospital or institution: **Wheatley Prod Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **6 weeks**
(Specify whether years, months or days)

In this community **6 months**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo**

(b) County **Jackson**

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

(d) Street No. **1210 Paseo**
(If rural, give location)

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

3. (a) PRINT FULL NAME **LONNIE JONES**

(b) If veteran, name war **No**

(c) Social Security No. **445-070941**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **2nd** year **1940** hour **3** minute **45 A.M.**

4. Sex **male** 5. Color or race **Negro**

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

6. (b) Name of ~~husband~~ wife **Bessie Jones**

6. (c) Age of husband or wife if alive **27** years

7. Birth date of deceased **June 23**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **October 3**, 19**40** to **November 2**, 19**40** that I last saw him alive on **Nov. 2**, 19**40** and that death occurred on the date and hour stated above.

8. AGE: Years **30** Months **4** Days **9** If less than one day hr. min.

Immediate cause of death **Broncho-Pneumonia Acute**

Due to **Toxemia**

9. Birthplace **Kellyville Okla.**
(City, town, or county) (State or foreign country)

Due to **1360**

Other conditions **Acute Articular Arthritis**
(Include pregnancy within 3 months of death)

10. Usual occupation **Porter**

Major findings: Of operations **Impassable Posterior urethral stricture**

Of autopsy _____

11. Industry or business _____

MOTHER FATHER

12. Name **Robert Johnson Jones**

13. Birthplace **Songalia Texas**
(City, town, or county) (State or foreign country)

14. Maiden name **Sadie Washburn**

15. Birthplace **Okl**
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **Bessie Jones**

(b) Address **1210 Paseo**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **no**

(b) Date of occurrence _____

17. (a) **St John** (b) Date thereof **Nov 5, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sapulpa Okla.**

(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? _____

18. (a) Signature of funeral director **E. Stealing Bella**

(b) Address **1811 E 12th St. K.C. Mo**

While at work? _____ (Specify type of place) (c) Means of injury _____

19. (a) **11-5-40** (b) **M. M. Grove**
(Date received local registrar) (Registrar's signature)

23. Signature **D. L. Tutillman** M. D. or other **M. D.**

Address **1618 Lydia** Date signed **11/5/40**

AUG 23 1949

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. *J. Sterling Bills*
3178

P. O. Address *1811 E. 12th St. Hk.*

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, fact should be so stated above.