

Registration District No. 10240

Primary Registration District No. 6280

Registrar's No. 79

1. PLACE OF DEATH:

(a) ~~CLAY~~ CLAY  
(b) ~~City or town~~ R.F.D. #2 LIBERTY MO.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community TWO YEARS \_\_\_\_\_ (Specify whether  
years, months or days) \_\_\_\_\_

3. (a) PRINT FULL NAME KATHRINE JONES

3. (b) If veteran, name war L 3. (c) Social Security No. L

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife EARL VAN JONES 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased MAY 19 1892  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
48 5 13 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business \_\_\_\_\_

12. Name FRANK J. LAWRENCE

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

14. Maiden name LENA CORCELIUS

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

16. (a) Informant's own signature \_\_\_\_\_

(b) Address R.F.D. # 2 LIBERTY MO.

17. (a) BURIAL (b) Date thereof II-5-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park K.C. MO.

18. (a) Signature of funeral director Neszel-Bardes

(b) Address LIBERTY MO.

19. (a) II-5-40 (b) Helen Early  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County CLAY

(c) City or town R.F.D. #2 LIBERTY MO.  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 3  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Shot with 45 Caliber through the head

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

28. Signature Mrs W D Simpson (M.D. or other) \_\_\_\_\_

Address Liberty Mo. Date signed 11-5-40

Duration

gun shot wound

Shot with 45 Caliber through the head

\_\_\_\_\_

\_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

FORM 1 1931

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.

184

**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 Mani Hassel

Licensed Embalmer No. 25-09

P. O. Address Liberty 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38492  
Registrar's No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 201

Primary Registration District No. 5280

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD  
ROWENA MOORE

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Liberty T.P.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Katherine Jones

3. (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 48 Months 5 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) \_\_\_\_\_ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 3 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_; that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death gunshot wound that with 45-Caliber through the head.

Due to Coroner's jury decided above, do not know if accident, suicide or homicide.

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 Nov 3

(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? Home

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Mrs W. C. Young Coroner (M. D. or other) \_\_\_\_\_

Address Liberty Mo. Date signed 2-18-41

SUPPLEMENTARY

