

JAN 8 1941
 Registration District No. **999**

Primary Registration District No. **1002**

Registrar's No. **4913**

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

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:
K.C. General Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 day**
(Specify whether years, months or days)

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. **7219 Walrond**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

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

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Child**

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

7. Birth date of deceased **Dec. 21 1940**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days **1** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Child**

11. Industry or business _____

MOTHER FATHER { 12. Name **Melvih Jones**
 13. Birthplace **Arkansas**
(City, town, or county) (State or foreign country)
 14. Maiden name **Irene Morgan**
 15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Melvin Jones**

(b) Address **7219 Waldron Ave. K. C. Mo.**

17. (a) **Burial** (b) Date thereof **12-26-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenlawn**

18. (a) Signature of funeral director **Wailert Funeral Home**

(b) Address **2332 Monitor Plaza; K. C. Mo.**

19. (a) **12-26-40** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **21st**
 year **1940** hour **9** minute **40 P.** M.

21. I hereby certify that I attended the deceased from **12-20-40** to **12-21-40**
 that I last saw him alive on **12-21-40** and that death occurred on the date and hour stated above.

Immediate cause of death **Prematurity**

Due to **159**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **None**

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?

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

23. Signature **Amey R. Stone** (M. D. or other) _____
 Address **Med. Dir. K.C. Gen. Hospital** Date signed _____

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

Blaine E. Weiland

Licensed Embalmer No.

4075

P. O. Address

2332 Monitor Place

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.