

FILED APR 15 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9803

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State File No. 1212

Registration District No. _____

Primary Registration District No. 1002

Registrar's 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:
618 Inaust
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community ten years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 618 Inaust (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION 22

20. DATE OF DEATH: Month 3 day 28 - 41
year _____ hour _____ minute 7:24 M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him/her alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchodilation & Bronchopneumonia

Due to: Chronic Fibrous Nephrosclerosis

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 _____
(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)
While at work? _____ (e) Means of injury 3

23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed _____

3. (a) PRINT FULL NAME METTY JONES

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

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

6. (b) Name of husband or wife P. Jones 6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 85 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business na

12. Name unknown

18. 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 William Bryant

(b) Address 622 Argonne St

17. (a) Shelbidge (b) Date thereof mar 25 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Ideal Fun. Home

(b) Address 1409 E 19th St

19. (a) 3/25/41 (b) M. M. Crowe (Date received local registrar) (Registrar's signature)

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

L. B. Harris, Jr.

Licensed Embalmer No. *3388*

P. O. Address *K. 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.