

Registration District No. **399**

Primary Registration District No. **100v**

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 No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days** (Specify whether
In this community **35 Yrs.** 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. **2622 Indiana** (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Frank M. JONES.**

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 **Married**
6. (b) Name of husband or wife **Margaret Jones** 6. (c) Age of husband or wife if alive **55** years
7. Birth date of deceased **November 29th, 1870**
(Month) (Day) (Year)

8. AGE: Years **70** Months **4** Days **8** If less than one day hr. min.

9. Birthplace **Pekin Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Switchman**

11. Industry or business **K. C. Terminal R. R.**

MOTHER FATHER { 12. Name **Joel Jones**
13. Birthplace **Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Smith**
15. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Margaret Jones.**
(b) Address **2622 Indiana Ave.**

17. (a) **Burial** (b) Date thereof **4/9/41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Marys Cemetery**

18. (a) Signature of funeral director **Melody McGilley.**
(b) Address **K. C. Mo.**

19. (a) **Apr 8 1941** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **7th**
year **1941** hour **8** minute **30** A. M. P. M.

21. I hereby certify that I attended the deceased from **4-4-41** 19 to **4-7-41** 19
that I last saw him alive on **4-7-41** 19
and that death occurred on the date and hour stated above.

Immediate cause of death
Prostatic hypertrophy and adenoma;
Cystitis; Pericystic abscess and diverticula, Hydroureters and Nephrosis

Due to **1271**
Other conditions (Include pregnancy within 3 months of death) **1270**

Major findings:
Of operations
Of autopsy **See above**

Duration
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 **0**
23. Signature **Dr. R. K. Gen. Hospital** (M. D. or other)
Address **Med. Dir. K. C. Gen. Hospital** Date signed **4-8-1941**

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

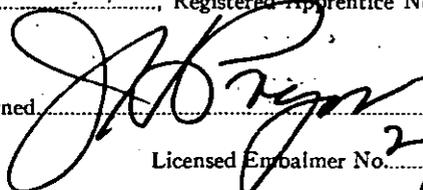
48
38

5

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.....

2999
KC

P. O. Address.....

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.