

Registration District No. 399

Primary Registration District No. 100

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 17 1/2 days
(Specify whether
 In this community 15 Years
years, months or days)
Melvin

3. (a) PRINT FULL NAME William A. Jones

3. (b) If veteran, name war World War

3. (c) Social Security No. 446-05-1031

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mrs. Josephine Jones

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased September 4 1885
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>7</u>	<u>13</u>	<u>1</u> hr. <u>1</u> min.

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

10. Usual occupation Chef

11. Industry or business

12. Name Unknown Jones

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

14. Maiden name Cherry Smith

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

16. (a) Informant Mrs. Josephine Jones

(b) Address 3949 St. John Avenue

17. (a) Cremation (b) Date thereof April 19, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D.W. Newemer's Sons Mortuary

18. (a) Signature of funeral director D. H. Newemer

(b) Address 1401 Brush Creek Blvd.

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

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. 3949 St. John
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17th
 year 1941 hour 11 minute 30 A.M. M.

21. I hereby certify that I attended the deceased from April 4, 1941 to April 17th 1941
 that I last saw him alive on April 17th 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Bilaterally pulmonary miliary and conglomerate tuberculosis with cavitation

Due to B B

Due to 13 13

Other conditions See above
(Include pregnancy within 3 months of death)

Major findings: Of operations See above
 Of autopsy See above

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? Med. Dir. K.C. Gen. Hospital
(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) (e) Means of injury

23. Signature Dr. R. D. ... (M.D.) 1941
 Address Med. Dir. K.C. Gen. Hospital Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Frank M. Calhoun

Licensed Embalmer No. 3506

P. O. Address: K E 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, fact should be so stated above.