

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1756

1. PLACE OF DEATH:

(a) County JACKSON  
(b) City or town KAW  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1111 East 8th St 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 12 years. (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County JACKSON 48  
(c) City or town KANSAS CITY 3  
(If outside city or town limits, write "RURAL") 8  
(d) Street No. 1111 East 8th  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) C  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5-8-41  
year hour minute 12:15 P.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: *Myocardial Infarction*  
Duration \_\_\_\_\_  
Due to: *46 H*

Due to: *46 H*  
Other conditions: *46 H*  
(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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
While at work? \_\_\_\_\_  
23. Signature *Quellw...* (M. D. or other) *9*  
Address *ECM* Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME ETHEL JONES  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. 496-09-1142

4. Sex FE 1 5. Color or race WH  
6. (a) Single, widowed, married, divorced MARRIED  
7. (b) Name of husband or wife THOMAS JONES 6. (c) Age of husband or wife if alive 53 years  
7. Birth date of deceased MAY 24 1891 (Month) (Day) (Year)

8. AGE: Years 49 Months 11 Days 9 If less than one day hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business ✓

MOTHER FATHER { 12. Name BOB - DAVIS  
13. Birthplace DONT-KNOW OMO (City, town, or county) (State or foreign country)  
14. Maiden name DONT-KNOW  
15. Birthplace DONT-KNOW 9 (City, town, or county) (State or foreign country)

16. (a) Informant Bernice Cronley  
(b) Address 1111 E. 8th St

17. (a) FLORAL HILLS (b) Date thereof 5-5-41 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation FLORAL HILLS CEM

18. (a) Signature of funeral director Howard R. Roe  
(b) Address 3146 Main  
19. (a) May 4 1941 (b) M. M. Cronley (Date received local registrar) (Registrar's signature)

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

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**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.....

*Howard J. Roe*

Licensed Embalmer No. 2748

P. O. Address 1324 E 36th

**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.**