

FILED OCT 13 1941
Registration District No. **349**

Primary Registration District No. **1002**

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:
7011 Edgevale Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community **22 Years** / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **048**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **7011 Ridgevale Road**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... **0**

3. (a) PRINT FULL NAME **Dr. Austin Byron Jones**

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

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

(b) Name of husband or wife **Roberta Jones** 6. (c) Age of husband or wife if alive **39** years

7. Birth date of deceased **Oct. 1, 1891**
(Month) (Day) (Year)

8. AGE: Years **49** Months **11** Days **2** If less than one day hr. min.

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

10. Usual occupation **Physician**

11. Industry or business

12. Name **Byron A. Jones**

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

14. Maiden name **Alice Rice**

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

16. (a) Informant **Mrs. Roberta Jones**

(b) Address **7011 Edgevale Road**

17. (a) **Burial** (b) Date thereof **9/6/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ridge Park Cem. Marshall, Mo.**

18. (a) Signature of funeral director **Mrs. C. L. Forster**

(b) Address **918 Brooklyn**

19. (a) **9/4/41** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **3rd** year **1941** hour..... minute **11 P.** M.

21. I hereby certify that I attended the deceased from **Mar 41** to **Sept 3 41** that I last saw him alive on **Sept 3 1941** and that death occurred on the date and hour stated above.
Immediate cause of death **Chronic myocarditis** Duration **939**

Due to **Hypertensive aortic dilation.**

Due to **Chr. Cholecystitis**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **938** Of autopsy **938**

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?
Mo.
While at work?..... (Specify type of place) (e) Means of injury.....
23. Signature **M. M. Crowe** (M. D. or other) **9-4-41**
Address **928 Profess Blvd** Date signed **9-4-41**

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

MOTHER FATHER

Dr. Kip Robison
Prof. Bldg.

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

Denzil C. Browning

Licensed Embalmer No. *2724*

P. O. Address

H. C. and

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.