

Filed OCT 13 1941
Registration District No. **299**

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:
422 West 16th Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 12 Years (Specify whether
In this community 12 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson X8
(c) City or town Kansas City 5
(If outside city or town limits, write "RURAL") 8
(d) Street No. 422 West 16th Street
(If rural, give location)
(e) Citizen of foreign country? No J. (Yes or No)
If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 18th
year 1941 hour 9 minute 10 A.M.

21. I hereby certify that I attended the deceased from
Sept 17 1941 to Sept 18 1941
that I last saw him alive on Sept 18
and that death occurred on the date and hour stated above:

Immediate cause of death Bronchopneumonia
Carcinoma of Lung 5mo
Duration
Due to ✓
Due to ✓

Other conditions (Include pregnancy within 3 months of death)
47d

Major findings: Of operations ✓
Of autopsy Bronchopneumonia
of Lung.
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?

While at work? (Specify type of place) (e) Means of injury
23. Signature Marion H. ... M.D. or Other
Address 315 ... Date signed 9/19/41

3. (a) PRINT FULL NAME Mrs. Ora B. JONES

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Mr. Albert H. Jones 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased December 9, 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
47 9 9 hr. min.

9. Birthplace Saline County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

12. Name Jordan Piper

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

14. Maiden name Unknown

15. Birthplace Saline County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Albert H. Jones
(b) Address 422 West 16th St

17. (a) Burial (b) Date thereof Sept. 20, 1941
(Burial, cremation, or removal) (City or town) (State) (Month) (Day) (Year)
(c) Place: burial or cremation Frankfort, Missouri

18. (a) Signature of funeral director O. J. Newcomer's Sons
(b) Address 1401 Brush Creek Blvd.

19. (a) 9/19/41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

Dr. Wheeler
University of Kansas
H.

9-10

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..... *H. C. Newcomer*

Licensed Embalmer No. *4043*

P. O. Address *H. C. Newcomer*

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.