No. 2
-1-4-41
-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

DEC 22 1941

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 37515

Registrar's No. 4310

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: General Hospital No. 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11-10-41-11-16-41 (Specify whether In this community 35 years 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. 1814 E. 10th St. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MANUEL JONES

3. (b) If veteran, name war Spanish American

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased February (Month) 5 (Day) 1868 (Year)

8. AGE: Years 73 Months 9 Days 11 If less than one day ..... hr. ..... min.

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

10. Usual occupation Unemployed

11. Industry or business

FATHER
12. Name Deceased Unk
13. Birthplace (City, town, or county) Unk. (State or foreign country)

MOTHER
14. Maiden name Deceased
15. Birthplace (City, town, or county) Unk. (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 11-21-41 (Month) (Day) (Year)

(c) Place: burial or cremation Wadsworth

18. (a) Signature of funeral director Watkins Bros

(b) Address 1729 Lydia

19. (a) 11/21/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16 year 1941 hour 1 minute 05 a. M.

21. I hereby certify that I attended the deceased from November 10, 1941, to November 16, 1941; that I last saw him alive on November 16, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Right Broncho-Pneumonia - terminal

Due to Aortic Aneurysm (specific in type) and Arteriosclerotic

Due to Heart

Other conditions 20 D (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Same as above.

Duration

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)

While at work? (e) Means of injury

23. Signature [signature] (M. D. ~~or other~~)

Address Gen. Hosp. #2-600 E. 22 Date signed 11-19-41

(Licensed Embalmer's Statement on Reverse Side)

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 D. J. Manlove

Licensed Embalmer No. 3994

P. O. Address 2503 Highland

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.