

3. No. 2
4-13-40
5-17-39
PI X23189

State File No. _____

4851

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City Mo
(c) Name of hospital or institution: 3631 Askew
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 years / (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Ellen Jones

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

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

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 11 1867
(Month) (Day) (Year)

8. AGE: Years 74 Months 1 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation House Work

11. Industry or business _____

12. Name John VanMeter

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

14. Maiden name unknown

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

16. (a) Informant Mrs Ralph Hood

(b) Address 3631 Askew

17. (a) Burial (b) Date thereof Dec 30, 4
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Quindaro Cem

18. (a) Signature of funeral director Rose & Henderson

(b) Address Kansas City Mo

19. (a) Dec. 29, 1941 M. M. Brown (b) _____
(Date received local registrar) (Registrar's signature)

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. 3631 Askew
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26 41
year _____ hour _____ minute 30 A M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw _____ alive _____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Cerebral Encephalomalacia
Due to _____
Cerebral Vascular Occlusion
Due to _____
Cerebral Arteriosclerosis
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations 830
Of autopsy _____

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 _____ Date signed _____

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

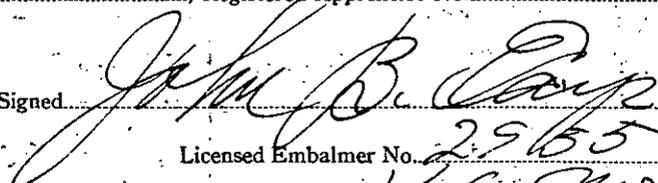
920

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.....

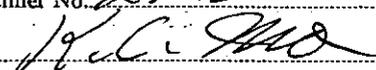
....., Registered Apprentice No.
working under my personal supervision.

Signed.....



Licensed Embalmer No. 2965

P. O. Address.....



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.