

FILED APR 8 1943 99
Registration District No. **399**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City Mo.**
(c) Name of hospital or institution: **Robinson Clinic, 2526 Paseo**
(d) Length of stay: In hospital or institution **4 days**
In this community **4 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Carroll**
(c) City or town **Carrollton**
(d) Street No. **3rd main st.**
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **GROYER-CLEVELAND JAMES.**

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

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

6. (b) Name of husband or wife **May Ellen Jones** 6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased **Sept 2, 1890**

8. AGE: Years **51** Months **6** Days **22** If less than one day hr. min.

9. Birthplace **Wale Mo.**

10. Usual occupation **Lawyer**

11. Industry or business

12. Name **Stone wall Jackson Jones**

13. Birthplace **Mo.**

14. Maiden name **Ellen E. Jones**

15. Birthplace **Ohio**

16. (a) Informant **A. J. Jones**

(b) Address **Carrollton Mo.**

17. (a) **Burial** (b) Date thereof **Mar 26-42**

(c) Place: burial or cremation **Oak Hill**

18. (a) Signature of funeral director **Willis - Marshall**

(b) Address **Carrollton Mo.**

19. (a) **3-24-42** (b) **M. M. Crowe**

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **March** day **24** year **1942** hour **12** minute **15** PM

21. I hereby certify that I attended the deceased from **3-20-42** to **3-24-42** that I last saw him alive on **March 24, 1942** and that death occurred on the date and hour stated above.

Immediate cause of death **Broncho-pneumonia** Duration **12 hrs.**

Due to **Vaso-motor collapse** 12 hrs.

Due to **Delirium Tremens** 3 days

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **101**

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?

While at work? (Specify type of place) (e) (Specify type of injury)

23. Signature **Chas. Shelton** M.D. or other **MD**

Address **2675 Paseo** Date signed **3-24-42**

MAR 22 1949

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..... *R. M. Marshall*

Licensed Embalmer No. *25725*

P. O. Address..... *Carrollton, Mo.*

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.