

LED FEB 10 1943
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 406

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:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether 5 mo - 12 days)

In this community _____
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. 719 Penn St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Richard Jones

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex MALE 5. Color or race wht

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased AUG 16 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

5 8 16 hr. _____ min.

9. Birthplace KANSAS CITY, MO.
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business _____

MOTHER FATHER

12. Name CARL JONES

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

14. Maiden name BESSIE HARRIS

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

16. (a) Informant Mr. Carl Jones

(b) Address 719 Penn K.C. Mo

17. (a) Burial (b) Date thereof Jan 26 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Walter James Home

(b) Address 233 - Montauk Pl. K.C. Mo

19. (a) 1-26-43 (b) M. M. Cronin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 24th
year 1943 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from 1-23-43, 19____ to 1-24-43, 19____;
that I last saw him alive on 1-24-43, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Aspiration Pneumonia

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Major findings: Of operations _____

Of autopsy See above

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 Mary R. Jones (M. D. or other) _____
Address Med. Dir. K.C. General Hospital Date signed _____

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

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

Orin Samuelsen

Licensed Embalmer No. 3002

P. O. Address 2332 21st PL
MEMBER

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.