

FILED JUN 8 1943  
Registration District No. 42

Primary Registration District No. 1000

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Saint Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hospital  
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 2 days (Specify whether  
In this community 73 years (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town Saint Joseph //  
(If outside city or town limits, write "RURAL")

(d) Street No. 308 1/2 Field /  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME John Jones

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30  
year 1943 hour 11 minute 0 A.M.

21. I hereby certify that I attended the deceased from 4-27-1943 to 4-30-1943  
that I last saw him live on 4-30-1943  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased October 12, 1869  
(Month) (Day) (Year)

Immediate cause of death Accelerated Aortic Heart Disease

Due to Ch. Nephritis prev

Other conditions (Include pregnancy within 3 months of death) 131 lb

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

8. AGE: Years 73 Months 6 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace De Kalb, Missouri  
(City, town or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name Amos Kendall Jones

13. Birthplace De Kalb, Missouri  
(City, town, county) (State or foreign country)

14. Maiden name Sarah Jane Peabody

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

16. (a) Informant Mr. Florence Hoslip

(b) Address 2719 Locust Street

17. (a) Burial (b) Date thereof May 1, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Auburn Cemetery

18. (a) Signature of funeral director E.R. Sidenaden

(b) Address 602 So. 10th Street

19. (a) May 1, 1943 (b) Rae Heigoy  
(Date received local registrar) (Registrar's signature)

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) (Country) (State) \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Lepton Smith (M. D. or other) M.D.  
Address Wellbun Court Date signed 5/1/43

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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 *Mollie E. Sidenfaden Fox*  
Licensed Embalmer No. *4235*  
P. O. Address *St. Joseph 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.**