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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 20440

FILED JUN 30 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2723

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
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 day (Specify whether years, months or days)

In this community: 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48 3

(c) City or town: Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No.: ~~General Hospital~~ 4418 Cleveland
(If rural, give location)

(e) Citizen of foreign country? (Yes or No): 0

If yes, name country:

3. (a) PRINT FULL NAME: Jones Infant

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: single

6. (b) Name of husband or wife:

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

7. Birth date of deceased: June (Month) 13 (Day) 1943 (Year)

8. AGE: Years | Months | Days | If less than one day: 3 hr. 28 min.

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

10. Usual occupation: Infant.

11. Industry or business: child

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

MOTHER
14. Maiden name: Julia Jones
15. Birthplace: Kansas City (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: mother

(b) Address: 4418 Cleveland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-15-43 (Month) (Day) (Year)

(c) Place: burial or cremation: Greenlawn

18. (a) Signature of funeral director: Wm. A. Robinson

(b) Address: City Mortician

19. (a) 6-16-43 (Date received local registrar) (b) Dep. T. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13 year 1943 hour 8 minute 00 A. M.

21. I hereby certify that I attended the deceased from June 13, 1943, to June 13, 1943 that I last saw him alive on June 13, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
prematurity	
spina bifida, club feet	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:

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? (Specify type of place)

While at work?

(e) Means of injury:

23. Signature: Drury R. Thorn (M. D. or other)

Address: Date signed:

(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.....

Licensed Embalmer No.....

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.