

S. No. 2
FORM-2-43
Rev. 5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27364

State File No. 3689
Registrar's No. _____

SEP 7 1943
Registration District No. 149

Primary Registration District No. 1002

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

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: Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Judy La Vann Jones

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Femal 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 April 8 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 4 17 hr. min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER {
12. Name Jesse Jones
13. Birthplace Rogersville Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Mildred Eckert
15. Birthplace Kas.
(City, town, or county) (State or foreign country)

16. (a) Informant Mildred Jones
(b) Address Olathe Kansas
17. (a) Removal (b) Date thereof Aug 26 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Olathe Kansas

18. (a) Signature of funeral director Mrs C.L. Forster
(b) Address 918 Brooklyn

19. (a) Aug 26 1943 (b) D.E. Brown
(Date received legal registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Johnson
(c) City or town Olathe Kas
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country U

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 25
year 1943 hour 6 minute P. M.

21. I hereby certify that attended the deceased from Republic to Coroner 19____

that I last saw h. _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Broncho pneumonia
Due to Pertussis
Due to _____

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

Major findings: Of operations _____

Of autopsy inspection of history

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 A.E. Washer (M.D. or Chgo)
Address 237 N. 2nd Date 8/26/43

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

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 *Wenzel C. Browning*
.....
Licensed Embalmer No. *2724*
.....
P. O. Address *I. C. 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.