

17-39
X35897

Registration District No. **100**
FILED FEB 10 1944

Primary Registration District No. **100**

Registrar's No. **501**

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1005 Agnes
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 20 years years, months or days)

3. (a) PRINT FULL NAME Frank Milton Jones
3. (b) If veteran, name war none 3. (c) Social Security 496-09-4743

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs Lucina Jones 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased July 18 (Month) (Day) (Year)

8. AGE: Years 71 Months 6 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Rail Road

11. Industry or business _____

12. Name Do not know

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

14. Maiden name Do not know

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

16. (a) Informant Mrs Lucina Jones

(b) Address 1005 Agnes

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Bk. Ck.

18. (a) Signature of funeral director Pacantine Bros.

(b) Address Kansas City Mo.

19. (a) 1-31-44 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

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. 1005 Agnes (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 29 year 1944 hour 12 minute 10 AM.
21. I hereby certify that I attended the deceased from January 24, 1944, to Jan. 29, 1944, that I last saw him alive on Jan. 28, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to Myocardial insufficiency

Due to Influenzal pneumonia

Other conditions Arteriosclerosis and bronchial asthma (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy 932

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 William P. Adams (M. D. or other) D. O.

Address 1145 Prospect Date signed 1/29/44

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

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 *Paul G. Rowe*

Licensed Embalmer No. *2347*

P. O. Address *H. C. 700*

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.