No. 2
9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1944

Registration District No. ____

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 1496

Registrar's No. 343

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K.C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. T.B. Hosp. O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1018 days (Specify whether
In this community 234 & 3 m.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town Kansas City
(If outside city or town limits, write "RURAL") 0

(d) Street No. 2452 Woodland
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country O

3. (a) PRINT FULL NAME JONES, JUDINE

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race Negro

6. (a) Single, widowed, married, divorced 3 Divorced

6. (b) Name of husband or wife Marcus Butler

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

7. Birth date of deceased January (Month) 1 (Day) 1921 (Year)

8. AGE: Years 23 | Months — | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Fleming, Mo (City, town, or county) O (State or foreign country)

10. Usual occupation Maid

11. Industry or business

FATHER
12. Name Charles Jones
13. Birthplace Lexington Mo (City, town, or county) O (State or foreign country)

MOTHER
14. Maiden name Laura Kyfir
15. Birthplace Arkansas, Mo (City, town, or county) O (State or foreign country)

16. (a) Informant Records of K.C.T.B. Hosp.

(b) Address Kansas City, Missouri

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 1/21/44 (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

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

(b) Address 1729 Lydia

19. (a) Jan 27, 1944 (Date received local registrar) (b) F E Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17
year 1944 hour 5 40 minute A M.

21. I hereby certify that I attended the deceased from 4-4-41, 19__, to 1-17, 1944
that I last saw her alive on January 17, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis — Duration 3 4 9 m

Due to 13 6'

Due to

Other conditions T.B. Laryngitis — 3 mo
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Same as above

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 O

23. Signature Matthew J. Noon (M. D. or other)

Address K.C. T.B. Hosp. Date signed 1/17/44

(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. I. Jerome Manlove

Licensed Embalmer No. 3994

P. O. Address 2503 Highland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.