

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 1944

944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

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: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days
(Specify whether years, months or days)

In this community 5 Years
(Specify whether years, months or days)

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. 1429 Holmes
(If rural, give location)

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

3. (a) PRINT FULL NAME Thomas S. Jones

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Pirdie Jones 6. (c) Age of husband or wife if alive * 1870 years

7. Birth date of deceased Nov. 8th.
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>73</u> | <u>3</u> | <u>20</u> | hr. _____ min. _____ |

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

10. Usual occupation Farmer Retired

11. Industry or business _____

12. Name Jones

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

14. Maiden name No Record

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Wm. M. Beals

(b) Address 3711 East 11th. Street

17. (a) Burial (b) Date thereof 2-28-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address K. C. Mo.

19. (a) 2-28-44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 26
year 1944 hour 6 minute 40 A. M.

21. I hereby certify that I attended the deceased from February 8, 1944, to February 26, 1944, that I last saw him alive on February 26, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Tabes-Uremia with circulatory failure
(cord bladder)

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy See above

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) _____
Means of injury _____

23. Signature T. E. Brown Med. Dir. D. M. O.
Address 22 M. Day Date signed 2-28-44
(M. D. or other) (Date signed)

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

MOTHER FATHER

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

Thomas R. Redman

Licensed Embalmer No.

2437

P. O. Address

R. P. 120

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.