

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo Pac. Hosp Assn.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 hours 45 min
(Specify whether _____)
In this community No.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Atchison
(c) City or town Atchison
(If outside city or town limits, write "RURAL")
(d) Street No. 209 No 15th St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Herbert Lemuel Jones

(b) If veteran, name war _____

(c) Social Security No. 702-14-3445

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased 11 11 1872
(Month) (Day) (Year)

8. AGE: Years 72 Months 0 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation Pensioned RR. Engineer

11. Industry or business Railroad Mo Pac.

12. Name George Jones

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

14. Maiden name Unknown

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

16. (a) Informant Blam Jones
(b) Address Omaha Neb

17. (a) Removal (b) Date thereof 11-25-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Atchison, Kansas
(d) Signature of funeral director Albert H. Hoppe
(e) Address 4700 Washington Blvd.

19. (a) 11-28-44 (b) J. B. Deck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 25
year 1944 hour 7 minute 40 A. M.

21. I hereby certify that I attended the deceased from Nov 24, 1944 to Nov 25, 1944.

that I last saw him alive on Nov 25, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure 3 days Duration

Due to Coronary occlusion

Due to _____

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

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? _____

While at work? Yes (Specify type of place) (e) Means of injury PH
23. Signature PH (M. D. or other) PH
Address Mo Pac Hosp Assn Date signed 11/25/44

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

20
17
9

10125
10125

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 *Albert G. Hoffer*.....

Licensed Embalmer No. *2971*.....

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.