

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 8 days  
(Specify whether years, months or days) 0  
In this community 30 years

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. 1003 Cherry  
(If rural, give location) No  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME

John R. Jones

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Ma

5. Color or race Wh

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

6. (b) Name of husband or wife Olive E. Jones

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

7. Birth date of deceased February 26 1868  
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 28  
If less than one day hr. min. 10

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

10. Usual occupation Oil Distributor

11. Industry or business

12. Name Charles Jones  
13. Birthplace Tenn.  
(City, town, or county) (State or foreign country)  
14. Maiden name No Record  
15. Birthplace Tenn.  
(City, town, or county) (State or foreign country)

16. (a) Informant Olive E. Jones

(b) Address 1003 Cherry

17. (a) Burial (b) Date thereof 12-14-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) 12-13-44 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 12  
year 1944 hour 7 minute 50 A.M.

21. I hereby certify that I attended the deceased from Dec. 4 1944 to Dec. 12 1944  
that I last saw him alive on Dec. 12 1944  
and that death occurred on the date and hour stated above.  
Immediate cause of death Bronchopneumonia Duration

Due to Benign hypertrophy of prostate

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 107

Major findings: Of operations \_\_\_\_\_  
Of autopsy See 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? \_\_\_\_\_

While at work? (Specify type of place) \_\_\_\_\_  
(e) Manner of injury MO.  
23. Signature A. E. Upsher (M. D. or other) MO.  
Address Med. Dir. Gen'l Hosp. Date signed 12-12-44

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

MOTHER FATHER

**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 *A.R. Hunschled*

Licensed Embalmer No. *4159*

P.O. Address *Kansas City 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.**