S. No. 2
M—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 7 1945

Registration District No. 749

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

5207

State File No.

Primary Registration District No. 1002

855

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: 2604 CHESTNUT AVENUE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ---
In this community 63 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. 2604 CHESTNUT AVENUE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country ---

48
3
8

3. (a) PRINT FULL NAME MRS ATHA CATHERINE JONES
3. (b) If veteran, name war NO
3. (c) Social Security No. NONE

4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife MR BYRD JONES
6. (c) Age of husband or wife if alive --- years
7. Birth date of deceased MARCH (Month) 15 (Day) 1862 (Year)

8. AGE: Years 82 Months 11 Days 5 If less than one day ___ hr. ___ min.

9. Birthplace SULPHER SPRINGS (City, town, or county) KENTUCKY (State or foreign country)
10. Usual occupation AT HOME
11. Industry or business ---
FATHER
12. Name JOHN P. WEST
13. Birthplace INDIANA (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name KATHERINE SADDELWHITE
15. Birthplace KENTUCKY (City, town, or county) (State or foreign country)
16. (a) Informant MISS NETTIE WEST
(b) Address 2644 EAST 28TH STREET
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 22 1945 (Month) (Day) (Year)
(c) Place: burial or cremation ELMWOOD CEMETERY
18. (a) Signature of funeral director D. V. Newcomer's Sons
(b) Address 1401 BRUSH CREEK BLVD.
19. (a) 2-21-45 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 20TH year 1945 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from February 18, 1945 to February 20, 1945 that I last saw her alive on February 19, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arterial Hypertension	10-15 yrs
Due to Senility	
Other conditions (Include pregnancy within 3 months of death) 94	

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? ✓ (Specify type of place)
(e) Means of injury 2

23. Signature U. W. Harned (M. D. or other) DO
Address 406 Wilkerson Bldg Date signed 2-20-45

(Licensed Embalmer's Statement on Reverse Side)

Wilkinson Bldg
Board of Health

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC 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.