

FILED MAR 1 1945

State File No. \_\_\_\_\_

Registration District No. 147

Primary Registration District No. 1002

Registrar's No. 924

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 15 days  
In this community 60 YEARS  
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. 412 1/2 East 15th St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME BERTHA Ada Jones

3. (b) If veteran, name war No 3. (c) Social Security No. NO ONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced 3 divorced DIVORCED  
6. (b) Name of husband or wife MR. JOE ELLISON 6. (c) Age of husband or wife if alive MAY 16 1875  
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 69 Months 9 Days 8 If less than one day hr. min.

9. Birthplace MACON COUNTY MISSOURIA  
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business \_\_\_\_\_

12. Name GEORGE W. JONES  
13. Birthplace UNKNOWN MISSOURIA  
(City, town, or county) (State or foreign country)  
14. Maiden name SUSAN C. GREER  
15. Birthplace UNKNOWN MISSOURIA  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. MINNIE E. RICKMERS  
(b) Address 7309-MAIN STREET

17. (a) BURIAL (b) Date thereof FEB. 27 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director W. H. Newcomer's Son  
(b) Address 1401 BRUSH CREEK BLVD.

19. (a) e-26-45 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24th  
year 1945 hour 1 minute 45 A. M.

21. I hereby certify that I attended the deceased from 2-9-45 1945 to 2-24-45 1945  
that I last saw him er alive on 2-24-45 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Hypertensive heart disease  
Cirrhosis of liver with ascites

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 124/5

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) (e) Means of injury \_\_\_\_\_  
23. Signature Clark W Seelye M.D. (M. D. or other)  
Address Med. Supt. K.C. Gen. Hospital Date signed 2-24-45

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

82 508

**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. C. Newcomer Jr.*  
Licensed Embalmer No. *4043*  
P. O. Address *A. C. 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.**