

FILED MAY 11 1945

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **493**

1. PLACE OF DEATH:
(a) County **Lucykenon**
(b) City or town **Springfield Ma**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **State Hospital # 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **yes** (Specify whether years, months or days)
In this community **43 yrs 6 mos 8 days**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Ma** (b) County **Daline**
(c) City or town **Marshall Ma** (If outside city or town limits, write "RURAL")
(d) Street No. **1** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0 7**

3. (a) PRINT FULL NAME **Lucy E. Jones**
(b) If veteran, name war **no**
(c) Social Security No. **no**

4. Sex **Female** 5. Color or race **white**
(a) Single, widowed, married, divorced **single**
(b) Name of husband or wife
(c) Age of husband or wife if alive years (Day) (Year)

7. Birth date of deceased: **4 10 1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 0 22 hr. min.

9. Birthplace: **Marshall Ma**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business **no**

12. Name **not given**

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

14. Maiden name **Ma**

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

16. (a) Informant **State Hospital records**
(b) Address **Springfield Ma**

17. (a) **Removal** (b) Date thereof **5-3-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kansas City Mo**

18. (a) Signature of funeral director **M. L. K. Fritze**
(b) Address **Kansas City Mo**

19. (a) **5-3-45** (b) **Belmont Pichler**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **5** day **2** year **1945** hour **9:40** minute **10** M.

21. I hereby certify that I attended the deceased from **Jan 1st 1940** to **May 2 1945**
that I last saw her alive on **May 2 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Thrombosis of the heart died suddenly**

Due to **Bruise of femur 2 wks**

Due to **fell out of bed about 2 weeks ago**

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

Major findings: Of operations **ADDITIONAL SUPPLEMENTARY INFORMATION**
Of autopsy **ADDITIONAL SUPPLEMENTARY INFORMATION**

Duration
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) **11**

(b) Date of occurrence **5**

(c) Where did injury occur? (City or town) (County) (State) **5**

(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 **0**

23. Signature **O. E. Thomas** (M. D. or other)
Address **State Hospital 2 Springfield 5/3/45**

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

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 *C. H. Wise*

Licensed Embalmer No. 2590

P. O. Address Kansas City 2

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.

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH: Buchanan
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Lucey E. Jones
3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 12 1906
(Month) (Day) (Year)

8. AGE: Years 76 Months 0 Days _____ (If less than one day, _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 12 Year 1982
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions None other
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy 1860-5

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 Acute Hospital #2
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
ON the west side of St. Joseph #2

While at work _____ (Specify type of place) _____
(e) Means of injury fell to floor

23. Signature B. E. Ross (M. D. or other) _____

Address Acute Hospital #2 _____

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

SUPPLEMENTARY

12880