

**FILED JUN 11 1945**  
Registration District No. 1/17

Primary Registration District No. 1002

Registrar's No. 2343

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:  
General Hospital No. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5-22-45-5-27-45  
(Specify whether years, months or days)

In this community 42 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson <sup>48</sup>

(c) City or town Kansas City <sup>5</sup>  
(If outside city or town limits, write "RURAL") <sup>8</sup>

(d) Street No. 1735 Highland  
(If rural, give location)

(e) Citizen of foreign country? no <sup>0</sup> (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ROSA JONES, Rosetta

3. (b) If veteran, name was no

3. (c) Social Security No. none

4. Sex female 5. Color or race Negro

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation none

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

12. Name George Williams

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

14. Maiden name Sophie

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

16. (a) Informant Record Clerk  
(b) Address Gen. Hosp. #2.

17. (a) Burial (b) Date thereof 5-31-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Brady Brown

(b) Address 1708 O'grady

19. (a) 5-31-45 (b) Sheldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27  
year 1945 hour 2:40 minute a. M.

21. I hereby certify that I attended the deceased from May 22, 1945, to May 27, 1945, that I last saw her er alive on May 27, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolus Duration \_\_\_\_\_

Due to Pulmonary Thrombosis

Due to Arteriosclerotic type heart disease

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

Major findings: 93 d  
Of operations \_\_\_\_\_

Of autopsy same as 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 kind of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Gen. Hosp #2-600 E. 22 Date signed 5-29-45

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.....

Licensed Embalmer No. 1271

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.**