

S. No. 2
OM-5-43
v. 5-17-39
I X36671

15921

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 4 1945
199

Primary Registration District No. 1002

Registrar's No. 2212

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:
4906 Wornall Road
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 23 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. 4906 Wornall Road
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM HERBERT JONES

3. (b) If veteran, name war No

3. (c) Social Security No. 513-14-1209

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22nd year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Jan 9 1944 to May 22 1945 that I last saw him alive on May 10 1945 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Jean Jones

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

7. Birth date of deceased January 29th 1887
(Month) (Day) (Year)

Immediate cause of death Coronary Occlusion
Complicated Heart Failure
Atherosclerotic Heart Disease

Due to _____

Duration 17 yr.
5+ yr.

Other conditions (include pregnancy within 3 months of death) 93 d

8. AGE: Years Months Days If less than one day

58	3	23	hr.	min.
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9. Birthplace Fort Dodge Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Accountant

11. Industry or business _____

12. Name Benjamin Jones

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

14. Maiden name Mary E. Martin

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant Leah M. Jones

(b) Address 4906 Wornall Road

17. (a) Burial (b) Date thereof 5 / 24 / 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Freeman Mortuary & Chapel

(b) Address 104 West 42nd. Street

19. (a) 5-22-45 (b) Shaldine Holmes
(Date received local registrar) (Registrar's signature)

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? _____

(Specify type of place)

While at work? _____ (c) Means of injury _____

23. Signature Frank B. Jones (M. D. or other) M.D.
Address 924 P. 27 Rd. Date signed 5-22-45

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

Dr. Frank B. Lutz
Coff Bldg
2-5:30 pm

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 Elmer C. Widelin
Licensed Embalmer No. 3495-
P. O. Address N. C. Ill.

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.