

FILED OCT 13 1945

Registration District No. **147** Primary Registration District No. **1002**

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

48
3
8

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:
Trinity Lutheran 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **6 days**
(Specify whether years, months or days) **6 days** (Specify whether)

3. (a) PRINT FULL NAME **Ella D. Jones**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **F** 3 5. Color or race **W**

6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife

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

7. Birth date of deceased **July 1887**
(Month) (Day) (Year)

8. AGE: Years **58** Months **2** Days **0** If less than one day hr. min.

9. Birthplace **McLouth Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **School Teacher**
Public Schools

11. Industry or business

MOTHER FATHER { 12. Name **Robert B. Jones**

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

14. Maiden name **Judith Glynn**

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

16. (a) Informant **Phyllis Jones**

(b) Address **Salt Lake City Utah**

17. (a) **removal** (b) Date thereof **9 27 45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **McLouth, Kansas**

18. (a) Signature of funeral director **W. A. Sullivan**

(b) Address **McLouth**

19. (a) **10-2-45** (b) **Stearling Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Jefferson 999**

(c) City or town **McLouth** (If outside city or town limits, write "RURAL") **94**

(d) Street No. **0** (If rural, give location)

(e) Citizen of foreign country? **2** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **24** year **1945** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **Sept 17/45** to **19** that I last saw her alive on **Sept 24/45** and that death occurred on the date and hour stated above.

Immediate cause of death **Lymphocytic Thyroiditis with collapse of Trachea.**

Due to _____

Due to _____

Other conditions **630**
(Include pregnancy within 3 months of death)

Duration **5 wks**

Major findings: **Huge Thyroid Gland with tracheal displacement & laryngeal paralysis**

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 _____

23. Signature **Phyllis H. Ogilvie** (M.D. or other) **10/1/45**
Address **730 Prof Bldg** Date signed _____

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.....

W. A. Jones

Licensed Embalmer No. *3503*

P. O. Address *W. Kansas*

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.