

FILED OCT 4 1945 STANDARD CERTIFICATE OF DEATH

30153

State File No. 30153

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 985

1. PLACE OF DEATH:

(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:
1415 Felix /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days) 1 year

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan //
(c) City or town St. Joseph /
(If outside city or town limits, write "RURAL") 7
(d) Street No. 1415 Felix
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Louisa M. Jones

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex female / 5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife John K. Jones
6. (c) Age of husband or wife if alive years 1858
7. Birth date of deceased May 8 1858
(Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 7 If less than one day hr. min.

9. Birthplace Buchanan County Missouri (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name James Dysart
13. Birthplace Mt. Vernon Kentucky (City, town, or county) (State or foreign country)
14. Maiden name Louisa Harris
15. Birthplace Mt. Vernon Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Miss V. Marguerite Jones
(b) Address 1415 Felix
17. (a) burial (b) Date thereof 9/17/45 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lower Cemetery

18. (a) Signature of funeral director Dealer Better & Bowman
(b) Address 319 South 10th ST. JOSEPH
9/18/45
19. (a) (Date received local registrar) (b) H. Nestlebuch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 15th
year 1945 hour 9 minute 15 P M.

21. I hereby certify that I attended the deceased from Aug. 18 1945 to Sept. 15 1945;
that I last saw her alive on Sept. 15 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocardial insufficiency
Due to arteriosclerosis General

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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 Gustav Han (M. D. or other) M.D.
Address International Bldg. 510 1/2 W. 12th St. Date signed 9/17/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1424

Mr. H. A. Law
Turk Body

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 Gerald F. Wade

Licensed Embalmer No. 49722

P. O. Address St. Joseph

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.