

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **1501**
 Registrar's No. **451**

FILED FEB 11 1946
 Registration District No. **149**

Primary Registration District No. **1002**

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. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2 mos., 16 days**
 In this community **12 YEARS**
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson 48**
 (c) City or town **Kansas City 3**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **3128 Highland 8**
 (If rural, give location)
 (e) Citizen of foreign country? **No 0** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Laura M. Jones**
3. (b) If veteran, name war **No** **3. (c) Social Security No** **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan.** day **25**
 year **1946** hour **6** minute **58 P.M.**
21. I hereby certify that I attended the deceased from
Nov. 9 19 **45** to **Jan. 25** 19 **46**
 (that I last saw her alive on **Jan. 26** 19 **46**
 and that death occurred on the date and hour stated above.

4. Sex **FEMALE** **5. Color or race** **WHITE**
6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **MR. UNKNOWN JONES**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **MARCH-19-1885**
 (Month) (Day) (Year)

Immediate cause of death
fractured rt hip--Broncho-pneumonia
 Due to _____
 Due to _____

8. AGE: Years **60** Months **10** Days **6**
 If less than one day hr. _____ min. _____

Other conditions (include pregnancy within 3 months of death)
1962-5
 Major findings:
 Of operations _____
 Of autopsy _____

9. Birthplace **JACKSON NEBRASKA**
 (City, town, or county) (State or foreign country)
10. Usual occupation **AT HOME**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **accident**
 (b) Date of occurrence **11-9-45**
 (c) Where did injury occur? **2941 Forest, Kansas City, Mo.**
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
in home
 (Specify type of place)
 While at work? **No** (e) Means of injury **fall**

11. Industry or business _____
12. Name **WILLIAM STENSON**
13. Birthplace **MISSOURI**
 (City, town, or county) (State or foreign country)
14. Maiden name **GEORGIA STROUD**
15. Birthplace **ILLINOIS**
 (City, town, or county) (State or foreign country)

23. Signature **Clark W. Seely** (M.D. or other) **1-26-46**
 Address **Med. Dir. Gen'l Hosp.** Date signed _____

16. (a) Informant **MRS. HUGH BERRY**
(b) Address **3128 HIGHLAND AVENUE**
17. (a) BURIAL (b) Date thereof **JAN-29-1946**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **FLORAL HILLS CEMETERY**
18. (a) Signature of funeral director **D. H. Newcomer's Sons**
(b) Address **1401-1403 BUSH CREEK BLVD.**
19. (a) 1-28-46 (b) **Shiraline Holmes**
 (Date received local registrar) (Registrar's signature)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

1063

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K. E. 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.