

FILED AUG 19 1946
Registration District No. 44

Primary Registration District No. 3026

State File No. 27434
Registrar's No. 282

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

48

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town INDEPENDENCE
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: INDEPENDENCE SANITARIUM (I)
(If not in hospital or institution, write street number or location)

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

In this community LIFETIME

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. 619 - EAST 9TH STREET
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME MR. ROLFE VERNON JONES

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MRS. ANNA M. JONES

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased MAY 2 1892
(Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation LETTER CARRIER

11. Industry or business _____

MOTHER FATHER { 12. Name CHARLES S. JONES

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

14. Maiden name BLANCHAE KAUSE

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

16. (a) Informant MRS. ANNA M. JONES

(b) Address 619 EAST 9TH STREET

17. (a) BURIAL (b) Date thereof Aug. 13 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director D. W. Newcomer done

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 8-14-46 (b) [Signature]
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 10TH
year 1946 hour 1 minute 35 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Posterior Coronary Occlusion,
acute

Due to _____

Due to _____

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

Major findings: Of operations 940

Of autopsy see above

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 [Signature] (M. D. or other) _____

Address 12800 Main Date 8/14/46

SEP 10 1946

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 KC 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.