

No. 2
1-5-43
I X36671

FILED OCT 28 1946
1949

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 6 days
(Specify whether years, months or days) 33 years

3. (a) PRINT FULL NAME Warren W. Jones

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

4. Sex Ma 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Margaret E. Jones 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased October 30 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 11 26 hr. min.

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

10. Usual occupation Retired

11. Industry or business Hotel Operator

12. Name Abraham Jones

13. Birthplace No Record

14. Maiden name No Record

15. Birthplace " "

(Mrs., town, or county) (State or foreign country)

16. (a) Informant Mrs. Mabel Thompson

(b) Address 612 East 9th

17. (a) Burial (b) Date thereof 9-28-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) 9-27-46 (b) Geraldine Holme
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 612 E. 9 St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Sept. day 26
year 1946 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from Sept. 20 46 to Sept. 26 46
that I last saw him alive on Sept. 26 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized arteriosclerosis Duration

Due to

Due to

Other conditions 97
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

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 W. W. Wagner (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 9-26-46

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

MOTHER FATHER

Dr. Whitehouse

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..... *Cecil R. Matthis*

Licensed Embalmer No. *3807*

P. O. Address..... *Kansas City, 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.