

V. S. No. 2  
DM-9-4-41  
Rev. 5-17-39  
I X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **21017**  
Registrar's No. **2697**

FILED JUL 3 1947  
Registration District No. **1002**

Primary Registration District No. **1002**

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

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. 2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **9 DAYS**  
(Specify whether years, months or days) **50 YRS.**

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") **8**  
(d) Street No. **2314 W. TERRACE**  
(If rural, give location) **( )**  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **LAURA JONES**

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month **JUNE** day **19**, year **1947** hour **10:** minute **50 P.M.**

4. Sex **FEMALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **MARRIED**

21. I hereby certify that I attended the deceased from **JUNE 10, 1947** to **JUNE 19, 1947** that I last saw him **ER** alive on **JUNE 19, 1947** and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife **WILL JONES** 6. (c) Age of husband or wife if alive **77** years

Immediate cause of death **HYPERTENSIVE HEART DISEASE** Duration

7. Birth date of deceased **DECEMBER 20, 1874**  
(Month) (Day) (Year)

8. AGE: Years **72** Months **5** Days **29** If less than one day hr. min.

9. Birthplace **ROLLINS MISSOURI**  
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business

MOTHER FATHER  
12. Name **CARL MARTIN** **9**  
13. Birthplace **unknown** (State or foreign country) **9**  
14. Maiden name **SARAH BARNETT**  
15. Birthplace **unknown** (State or foreign country) **9**

16. (a) Informant **WILL JONES (HUSBAND)**  
(b) Address **2314 W. TERRACE**

17. (a) **Buried** (b) Date thereof **6/23/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Highland Cemetery**

18. (a) Signature of funeral director **W. H. ...**  
(b) Address **1212 Vine St. N.C. ...**

19. (a) **6-23-47** (b) **Sheldine Holmes**  
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **93 d** Of autopsy  
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) (c) Means of injury **0**

23. Signature **Frank ...** (M. D. or other) **M.D.**  
Address **GENERAL HOSPITAL NO. 2** Date signed **6/20/47**

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**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..... *E. Sterling Bell*.....  
Licensed Embalmer No. *3178*  
P. O. Address. *1212 Vine St., K.C., 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.**