

FILED AUG 26 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas cy Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: KCTB Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 mo - 2 da  
(Specify whether years, months or days) 6 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas cy  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1113 E 17th apt 3A  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jones, Jesse Lee

3. (b) If veteran, name war - no 3. (c) Social Security No. 44-12-7921

4. Sex ma 5. Color or race N 6. (a) Single, widowed, married, divorced M /

6. (b) Name of husband or wife Dorothy Jones 6. (c) Age of husband or wife if alive 21 years

7. Birth date of deceased 9-8-1916  
(Month) (Day) (Year)

8. AGE: Years 30 Months 11 Days 1 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name Lee Jones

13. Birthplace Dennison Texas  
(City, town, or county) (State or foreign country)

14. Maiden name Phyllis Jack

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

16. (a) Informant KCTB Hospital

(b) Address Kansas cy Mo

17. (a) Burial (b) Date thereof 8-14-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cem

18. (a) Signature of funeral director Grady Brown

(b) Address 1708 Tracy

19. (a) 8-13-47 (b) Sheldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9 year 1947 hour 5:53 minute P M.

21. I hereby certify that I attended the deceased from 7-9, 1947 to 8-9, 1947 that I last saw him alive on 2-9, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 3 mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 138

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 \_\_\_\_\_

Signature A. R. Coffey M.D. (M. D. or other) \_\_\_\_\_

Address Kansas City Mo Date signed 8-9-47

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

MOTHER FATHER

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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.....

.....  
working under my personal supervision.

.....  
Registered Apprentice No. ....

Signed.....

.....  
Licensed Embalmer No. ....

P. O. Address.....

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.