

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED APR 17 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 1430

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. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 DAYS (Specify whether
In this community 30 YRS. years, months or days)

3. (a) PRINT FULL NAME JOHN JONES

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

4. Sex MALE 2 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive, years

7. Birth date of deceased JANUARY (Month) 1887 (Day) (Year)

8. AGE: Years 61 Months 1 Days 27 If less than one day hr. min.

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

10. Usual occupation LABORER

11. Industry or business _____

12. Name TOM JONES

13. Birthplace SOUTH CAROLINA (City, town, or county) (State or foreign country)

14. Maiden name SALLIE STAR

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

16. (a) Informant JOHN STAPLETON (FRIEND)

(b) Address 1200 E. 17TH STREET

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-1-1948 (Month) (Day) (Year)

(c) Place: burial or cremation LAWRENCE, Kansas

18. (a) Signature of funeral director Brady - Brown

(b) Address 1708 3rd

19. (a) 4-1-48 (Date received local registrar) (b) Heraldine Holmes (Registrar's signature)

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. 1200 E. 17TH STREET
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 20, year 1948 hour 6: minute 00 P. M.

21. I hereby certify that I attended the deceased from MARCH 12, 1948, to MARCH 20, 1948 that I last saw him IM alive on MARCH 20, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death ARTERIOSCLEROTIC TYPE OF HEART DISEASE

Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 93d

Major findings: Of operations _____

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 _____ (Specify type of place) _____ (Means of injury)

23. Signature [Signature] (M. D. or other) M. D.
Address GENERAL HOSPITAL NO. 2 Date signed 3/23/48

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

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 L. J. Harris Sr.

Licensed Embalmer No. 3388-Sr.

P. O. Address 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.