

S. No. 300
DM-10-47
Rev. 5-17-39
I 3908

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

19526
State File No. _____
2627
Registrar's No. _____

FILED JUL 3 1948
Registration District No. _____

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:
TRINITY LUTHERAN HOSP. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 DAYS (Specify whether years, months or days)
In this community 15 YRS. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 4029 WALNUT (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country NO

3. (a) PRINT FULL NAME MR. CHARLES JANES
3. (b) If veteran, name war NO
3. (c) Social Security No. NO

4. Sex M O
5. Color or race W
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MRS. IRENE JANES
6. (c) Age of husband or wife if alive unk. years
7. Birth date of deceased MARCH 10 1879
(Month) (Day) (Year)

8. AGE: Years 69 Months 3 Days 12 If less than one day hr. min.

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

10. Usual occupation RETIRED

11. Industry or business

MOTHER FATHER
12. Name M.W. JANES
13. Birthplace PENN. (City, town, or county) (State or foreign country)
14. Maiden name ELLEN SMITH (City, town, or county) (State or foreign country)
15. Birthplace NEW YORK (City, town, or county) (State or foreign country)

16. (a) Informant MRS. IRENE JANES

(b) Address 4029 WALNUT

17. (a) BURIAL (b) Date thereof 6-25-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. WASHINGTON

18. (a) Signature of funeral director STINE & MCCLURE

(b) Address KANSAS CITY, MO.

19. (a) 6-23-48 (b) Beraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 22 year 1948 hour 3 minute 42 P.M.

21. I hereby certify that I attended the deceased from Pathologist to Pathologist, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac dilatation.
Due to Myocardial Infarction.
Due to Coronary Arteriosclerosis + Thrombosis.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations g. r. d.
Of autopsy 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 Jack Hill (M. D. or other) _____
Address 1415 N. 1st St. Kansas City, Mo. Date signed 27 June 48

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 Robert D Reed

Licensed Embalmer No. 8745

P. O. Address H. 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.