

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8466**
1347

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION VINEYARD PARK HOSPITAL		d. STREET ADDRESS (If rural, give location) 2420 Mc Coy	

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) REBECCA c. (Last) JONES		4. DATE OF DEATH (Month) (Day) (Year) MAR-24-1949	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV-22-1855
9. AGE (In years last birthday) 93 YEARS		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) FANNIE COUNTY TEXAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME SHORT	13b. MOTHER'S MAIDEN NAME REBECCA RIVERS	14. NAME OF HUSBAND OR WIFE ALFRED JONES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) -----	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME MRS. CARL WOLF ADDRESS 2420 Mc Coy, MO

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES (b) Arterio-sclerosis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) 332X II. OTHER SIGNIFICANT CONDITIONS (c) Fracture of left hip Conditions contributing to the death but not related to the disease or condition causing death. hemiplegia		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) none	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kansas City Jackson Mo.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Mar 16, 1949 10 AM	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR? Fell fracturing L. Hip.
22. I hereby certify that I attended the deceased from 16 Mar, 1949 , to 24 Mar, 1949 , that I last saw the deceased alive on 23 Mar, 1949 , and that death occurred at 7:45 m., from the causes and on the date stated above.		
23a. SIGNATURE S. G. Sheldon (Degree or title) M.D.	23b. ADDRESS 2501 Gillham	23c. DATE SIGNED 24 Mar. 49
24a. RURAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAR-24-1949	24c. NAME OF CEMETERY OR CREMATORY FORT SCOTT KANSAS
DATE REC'D BY LOCAL REG. 3-24-49	REGISTRAR'S SIGNATURE Sheldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE D. H. Newcomer ADDRESS 1401-18 JOSH CREEK KANSAS CITY MO.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

APR 8 1940

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

DOYLE W. DANIEL

Student Embalmer No. 248

working under my personal supervision.

Signed Doyle W. Daniel
Student Embalmer

Signed

Bernard L. Evans

Licensed Embalmer No. 4250

P. O. Address AC 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.