

FILED APR 23 1949

STANDARD CERTIFICATE OF DEATH

State File No. 12487
1562
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

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	
c. LENGTH OF STAY (in this place) 17 Yrs		d. STREET ADDRESS (If rural, give location) 501 Spruce	
d. FULL NAME OF HOSPITAL OR INSTITUTION Northeast Osteopathic			

3. NAME OF DECEASED (Type or Print)	a. (First) Mary	b. (Middle) Ethel	c. (Last) Jones	4. DATE OF DEATH (Month) (Day) (Year) April 7 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 27, 1895	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James W. Kent	13b. MOTHER'S MAIDEN NAME Allie B. Poor	14. NAME OF HUSBAND OR WIFE Wm J. Jones
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Wm J. Jones	ADDRESS 501 Spruce
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Adeno-Sarcoma stomach		INTERVAL BETWEEN ONSET AND DEATH 6 months
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) None Known		
	DUE TO (c) None		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			151A

19a. DATE OF OPERATION 3-9-49	19b. MAJOR FINDINGS OF OPERATION Adeno-Sarcoma Carcinoma of stomach	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kansas City Jackson Mo
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **3-1**, 19**49**, to **4-7**, 19**49**, that I last saw the deceased alive on **4-7**, 19**49**, and that death occurred at **3:15 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Frank E. Day, D.O.	23b. ADDRESS 4314 E 9th, K.C. Mo	23c. DATE SIGNED 4-9-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4/8/49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Bristol Virginia
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DATE REC'D BY LOCAL REG. 4-8-49	REGISTRAR'S SIGNATURE Sheldine Holman	25. FUNERAL DIRECTOR'S SIGNATURE John H. Skelton, K.C. Mo	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

48 2080

STATEMENT BY LICENSED EMBALMER

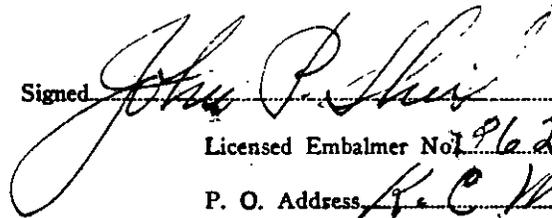
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 79625

P. O. Address R. C. W.

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.