

FILED OCT 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30358
State File No. 3915

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3915

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE #800 Jefferson MO. b. COUNTY Jackson 41	
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 Mo. 41	
c. LENGTH OF STAY (in this place) 10 yrs		d. STREET ADDRESS (If rural, give location) 4800 Jefferson	
d. FULL NAME OF HOSPITAL OR INSTITUTION Wheatley Hospital (P)			

3. NAME OF DECEASED (Type or Print) a. (First) Eva b. (Middle) Jones c. (Last) Jones			4. DATE OF DEATH (Month) (Day) (Year) SEP-9 1949		
--	--	--	---	--	--

5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan-17-1894		9. AGE (In years last birthday) 55		IF UNDER 1 YEAR Days		IF UNDER 12 HRS. Hours Min.	
---------------	--	--------------------------	--	--	--	------------------------------	--	------------------------------------	--	----------------------	--	-----------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (State or foreign country) Bandia County Tex-1		12. CITIZEN OF WHAT COUNTRY? U.S.A	
---	--	--	--	---	--	------------------------------------	--

13a. FATHER'S NAME Willie Williams		13b. MOTHER'S MAIDEN NAME Gracie Jones		14. NAME OF HUSBAND OR WIFE J.W. Jones	
------------------------------------	--	--	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME John W. Jones		ADDRESS 4800 Jefferson	
--	--	------------------------------	--	---	--	------------------------	--

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal Obstruction, Ileum				INTERVAL BETWEEN ONSET AND DEATH 48 Hrs.	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) CARCINOMA, OVARY, LEFT		6 Mos.	
				DUE TO (c) ANEMIA; SECONDARY, 60+		1 Mos.	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cholecystitis, Chronic 175X				18 Mos.	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Intestinal Obstruction Ileum & Carcinoma Ovary Left		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
------------------------	--	--	--	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
---	--	--	--	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
--	--	--	--	----------------------------	--

22. I hereby certify that I attended the deceased from August 1946, to Sept. 9, 1949, that I last saw the deceased alive on Sept 9, 1949, and that death occurred at 2 P.M., from the causes and on the date stated above.

23a. SIGNATURE Harold A. Budke (Degree or title)		23b. ADDRESS 317 A E WYME		23c. DATE SIGNED 9-12-49	
--	--	---------------------------	--	--------------------------	--

24a. BURIAL (Cremation, Removal) Burial		24b. DATE Sept-15-49		24c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		24d. LOCATION (City, town, or county) (State) I. C. Mo.	
---	--	----------------------	--	---	--	---	--

DATE REC'D BY LOCAL REG. 9-12-49		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE Trust Applington Jones		ADDRESS K.C. Mo.	
----------------------------------	--	--	--	---	--	------------------	--

WRITE PLAINLY - USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

[Handwritten signature]

Licensed Embalmer No. 2710

*1944
55
18*

R. O. Address K. E. ...

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.