

FILED MAY 14 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12638

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1796

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) 1 1/2 yrs.		d. STREET ADDRESS (If rural, give location) 4409 E. 9 St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1			

3. NAME OF DECEASED (Type or Print) a. (First) Jennie	b. (Middle) Nora	c. (Last) Jones	4. DATE OF DEATH (Month) (Day) (Year) 4 24 51
5. SEX F.	6. COLOR OR RACE w.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1885 10-5-86
9. AGE (In years last birthday) 65 1/2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	11. BIRTHPLACE (State or foreign country) Corder, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.			

13a. FATHER'S NAME Noah Jones	13b. MOTHER'S MAIDEN NAME Martha Hunter	14. NAME OF HUSBAND OR WIFE Warren Jones
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Warren Jones Kansas City, 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 3 3/4
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 April 23, 19 51, to April 24, 19 51, that I last saw the deceased alive on April 24, 19 51 and that death occurred at 10:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE B. I. Burns (Degree or title)	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 4-25-51
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 4-25-51	24c. NAME OF CEMETERY OR CREMATORY City Cem.
24d. LOCATION (City, town, or county) (State) Higginsville, Mo.		

DATE REC'D BY LOCAL REG. 4-25-51	REGISTRAR'S SIGNATURE Seraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Forrest A. Hooper Higginsville, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

Handwritten signature

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 *Forrest A. Hooper*

Licensed Embalmer No. *4358*

P. O. Address *Higginsville, 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.