

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **2624**

**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 St. Luke's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)  
In this community 20 Years

3. (a) PRINT FULL NAME Mr. Raymond O. Bone

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Maude Bone 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased April 28 1880  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
60 2 0 hr. min.

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

10. Usual occupation Partner

11. Industry or business Ray Optical Company

12. Name Albert Bone

18. Birthplace Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Bias

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R. O. Bone

(b) Address 432 West 69th Street

17. (a) Burial (b) Date thereof June 29, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral directors O. H. Newcomer Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) June 29, 1940 (b) M. M. Orme  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 432 West 69th Street  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 28th  
year 1940 hour 2 minute A. M.

21. I hereby certify that I attended the deceased from 1936  
19 to June 28 1940,  
that I last saw him alive on June 27 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Ventricular fibrillation Duration Instantaneous  
Due to Coronary thrombosis + myocardial infarction - left circumflex 6:25-40  
Due to Coronary Atherosclerosis 9400 Several years  
Other conditions High grade oral sepsis  
(Include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy Confirmed 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? \_\_\_\_\_  
(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury 1

23. Signature James H. Dargatzis (M. D. coroner)  
Address 315 Alameda Road Date signed 6-28-40

WRITE PLAINLY—USE UNFADING, BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

*Olga Medical Bldg*

**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 *C. Hervey Quisenberry*  
Licensed Embalmer No. *4070*  
P. O. Address *K. 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, above space should be left blank.**