MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

16625

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 4524

City St Louis Mo. (No. 3887 Bell St. ..... Ward)

2. FULL NAME Anna Jones.

(a) Residence. No. 3887 Bell St., 11 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. P mos. P ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Negro.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Tom Jones,

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 5th 1872

7. AGE: Years 55 Months 0 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Domestic 131 925
(b) General nature of industry, business, or establishment in which employed (or employer): ——
(c) Name of employer: ——

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Tennessee

PARENTS

10. NAME OF FATHER: Dock Buford.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Tennessee.

12. MAIDEN NAME OF MOTHER: Polly Buford.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Tennessee.

14. INFORMANT: Mable Barbey (Address) 3887 Bell

15. FILED MAY 14 1927 19 Max C. Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 11 1927

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to May 11, 1927 that I last saw b[illegible] alive on May 11, 1927 and that death occurred, on the date stated above, at 6.45 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

Apoplexy (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY): Nephritis-Chr

(duration) ..... yrs. ..... mos. ..... ds.

1294

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) Samuel P. Stafford M.D.

5-12, 1927 (Address) 925 N Jefferson Ave

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Franklin Tenn. DATE OF BURIAL: May 14th 1927

20. UNDERTAKER: A. L. Beal. ADDRESS: 2726 Lucas Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD