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

Do not use this space.

16941

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. Mo. Bapt. Sani. ..... St. ..... Ward)

File No. .....

Registered No. 4896

2. FULL NAME Jennie L. Jones

(a) Residence. No. 919 N Taylor St., 11 Ward.
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec. 18-1847

7. AGE: Years 79 | Months 5 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): Chester
(STATE OR COUNTRY): S. C.

PARENTS

10. NAME OF FATHER: Wallace Walters
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): S. C.
12. MAIDEN NAME OF MOTHER: Nancy Mackey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): S. C.

14. INFORMANT: Walter L. Jones
(Address) 4916 Forest Park Blv.

15. FILED MAY 25 1927 Max C. Starkloff REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 5-25-1927

17. I HEREBY CERTIFY, That I attended deceased from 4-1-27, 19..., to 5-25-1927, that I last saw her alive on 5/25-1927, and that death occurred, on the date stated above, at 11 P.M. 30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arteriosclerosis Gen
Myocarditis Chr.
93C
97
162
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Senility
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Phy. Finding

(Signed) R. K. Andrews, M. D.
5/25 1927 (Address) Wall Bedy

*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: Chester Ill.
DATE OF BURIAL: May 26 1927

20. UNDERTAKER: H. Rindskopf
ADDRESS: 5216 Delmar

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.

THIS IS A PERMANENT RECORD