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

Do not use this space.

35624

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 11430

City ..... (No. 3531 Page St. ..... Ward)

2. FULL NAME Ruth Jones

(a) Residence. No. ..... St., 21 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: Girl
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11. 18. 27

7. AGE: YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or 30 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER: E. Jones
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Evelyn ~~Jones~~ Rene
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St Louis Mo
(STATE OR COUNTRY)

14. INFORMANT: Father (E. Jones)
(Address) 3531 Page

15. FILED: DEC 21 1927 Mark C. Starr Coff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11. 18 1927

17. I HEREBY CERTIFY, That I attended deceased from 11. 18. 1927, to 11. 18. 1927, that I last saw her alive on 11. 18. 1927, and that death occurred, on the date stated above, at 10 30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature — 5 Mos.
Gestation —
159

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

CONTRIBUTORY (SECONDARY): Fell walking on street

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 8 161 A

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) T J Kemp, M. D

11/19, 1927 (Address) 1209 N Grand

*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: POTTERS FIELD. DATE OF BURIAL: 12-22-1927

20. UNDERTAKER: Ed Shannon VR Carol ADDRESS

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.

PERMANENT RECORD