

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

Do not use this space.

1. PLACE OF DEATH

County.....*St. Louis Mo.* Registration District No. **791**
 Township.....*St. Louis Mo.* Primary Registration District No. **1003** File No. **38620**
 City.....*St. Louis Mo.* (No. *Botheda Hosp*) Registered No. **11306** St. _____ Ward _____

2. FULL NAME

(a) Residence. No. *4323 Manchester* St., *18* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*
 6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept. 29-1927*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. ____ min.
2. 18.

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) _____
 (c) Name of employer _____

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

10. NAME OF FATHER *Gordon Jones*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Missouri*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Ruth Cerny*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Missouri*
 (STATE OR COUNTRY)

14. INFORMANT *Gordon Jones*
 (Address) *4323 Manchester Ave.*

15. FILED **DEC 18 1927** *maub Starceoff*
 _____ 19. _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec-17- 1927*

17. I HEREBY CERTIFY, That I attended deceased from *12-14*, 1927, to *12-17*, 1927
 that I last saw *living* alive on *12-17*, 1927, and that death occurred, on the date stated above, at *2 a* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Otitis meningitis
89H St. L. (duration) yrs. mos. *3* da.
 CONTRIBUTORY *Otitis media* (SECONDARY) (duration) yrs. mos. *7* da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: *home*

1 DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *12-15-27*

WHAT TEST CONFIRMED DIAGNOSIS *parenteral typhoid*
 (Signed) *W. B. Bailey* M. D.
 (Address) *3649 Vista*

*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 *Valhalla, Conn.* DATE OF BURIAL *Dec-18- 1927*

20. UNDERTAKER *Ambruster, Imdb 424* ADDRESS *Manchester*

WHITE PAINKILLER, WITH UNFADING INK---THIS IS A PERMANENT RECORD

X. R.—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.

10/10/50

10/10/50

EDA

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10/10/50

10/10/50

10/10/50

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. 11306
City..... (No. Bethesda Hosp.)..... St..... Ward.....

2. FULL NAME

Gordon Jones
(a) Residence. No. 4323 Manchester Ward..... (If nonresident give city or town and State)
(Usual place of abode)
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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 29/27</u>		
7. AGE	YEARS	MONTHS
		<u>3</u>
		DAYS
		<u>18</u>
		IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work		
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. J.A. III Stark REGISTRAR
FILED..... 19.....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 17 19 27

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.
, 19 (Address)

*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 DATE OF BURIAL
19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

WRITE PLAIN WITH UNFADING INK HIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. It should be stated EXACTLY. PHYSICIAN should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
FEE TRANS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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