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

Do not use this space.

791
E 003

25627

File No. 25627
Registered No. 7444

1. PLACE OF DEATH

County ..... Registration District No. E 003
Township ..... Primary Registration District No. .....
City ..... (No. 3117 Franklin Ave St. ..... Ward)

2. FULL NAME John Jones

(a) Residence. No. 3117 Franklin 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 10 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	Colored	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lallie D. Jones

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt	55			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer 131 92A
(b) General nature of industry, business, or establishment in which employed (or employer) 93E
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT Jennie Johnson
(Address) 3117 Franklin Ave

15. FILED JUL 19 1928 19 Mrs C Sowders REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 16, 1928

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1928, to July 16, 1928, that I last saw him alive on July 16, 1928, and that death occurred, on the date stated above, at 8:05 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac Insufficiency
Chronic Interstitial Nephritis
and Hemiplegia due to Cerebral
Hemorrhage Apoplexy (duration) yrs. Few mos. ds.

CONTRIBUTORY (SECONDARY) Acute Myocarditis
(duration) yrs. mos. Few 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? Clinical
(Signed) Erskine D. Johnson, M. D
, 19 (Address) 3201 Franklin Ave. Je-2519.

*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
Washington Park Cem	7-20 1928
20. UNDERTAKER	**ADDRESS**
People's Und Co	3109 Franklin 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.