

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

Do not use this space.

31824

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. City Infirmary  
City St. Louis Mo (No. ....) St. .... Ward)

**2. FULL NAME**

Amuday Jones  
(a) Residence. No. .... City St. Louis Mo St. 12 Ward. ....  
(Usual place of abode) City Infirmary  
Length of residence in city or town where death occurred 23 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female | 4. COLOR OR RACE Black | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) mo & day unknown 1843  
YEARS MONTHS DAYS IF LESS than 1 day, ... hrs. or ... min.  
84 Unknown

**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)**

(STATE OR COUNTRY) Kentucky

PARENTS

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Mrs Effinger  
(Address) City Infirmary

15. FILED SEP 11 1928 May C Stander REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/6 19 28

I HEREBY CERTIFY, That I attended deceased from 9/1/28 19 28, to 9/6 19 28, that I last saw her alive on 9/6/28, and that death occurred, on the date stated above, at 9:25 a.m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

930  
Chronic Myocarditis  
102  
(duration) 3 yrs. mos. da.

CONTRIBUTORY (SECONDARY) Senility  
(duration) ... yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? DATE OF ...  
WAS THERE AN AUTOPSY? none

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) Harold M. Gelp M.D.  
9/6 1928 (Address) 5700 St Louis

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Washington Park DATE OF BURIAL Sept 12 1928

20. UNDERTAKER J. H. Harrison and Co. ADDRESS 2906 Lawton

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.

