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

Do not use this space.

8350

**1. PLACE OF DEATH**

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1002

City St. Louis (No. City Hospital #2 St. ..... Ward)

File No. .....

Registered No. 2002

**2. FULL NAME** Smilie Mae Jones

(a) Residence. No. 2334 Carr 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. Life 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: Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 4, 1928

7. AGE: Years | Months 9 | Days 5 | If LESS than 1 day, ..... hrs. or ..... min.

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

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

PARENTS

10. NAME OF FATHER: Dan Jones

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

12. MAIDEN NAME OF MOTHER: Mary Cates

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

14. INFORMANT: Anna Filoodard
(Address) City Hospital #2

15. FILED DEC 12 1929, 19 Max C Starkey REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-9- 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-18-, 1929, to 2-9-, 1929 that I last saw her alive on 2-9-, 1929, and that death occurred, on the date stated above, at 9:40 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho-Pneumonia
Primary
107 ft
(duration) yrs. mos. 13 ds.

CONTRIBUTORY (SECONDARY) 1000
(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? Xray
(Signed) G. Cunningham, M. D
, 19 (Address) 2945 Fairton

*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: Washington Pk. | DATE OF BURIAL: Feb 12 1929

20. UNDERTAKER: W. C. Gordon Und Co | ADDRESS: 2649 Morgan St

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.