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

Do not use this space.

File No. 13174
Registered No. 5704

1. PLACE OF DEATH

County ..... Registration District No. 791 1003
Township ..... Primary Registration District No. .....
City St. Louis, Mo. (No. 5600, Arsenal St. 2 4th Ward)

2. FULL NAME William Jones

(a) Residence. No. 5713 Natural Bridge St., 7 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 1 mos. 23 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	white	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 2 - 1878

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	51	1	23	

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

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

PARENTS

10. NAME OF FATHER John W. Jones
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Illinois
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary - Morey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Illinois
(STATE OR COUNTRY)

14. INFORMANT Miss May Headrick
(Address) Isolation Hospital

15. FILED ..... 19.....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/25 1929

17. I HEREBY CERTIFY, That I attended deceased from 3/25, 1929, to 3/25, 1929, that I last saw him alive on 3/25, 1929, and that death occurred, on the date stated above, at 7:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Simple Meningitis (Pneumococci)
7 Sec (duration) yrs. mos. 2 ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 5713 Natural Bridge.

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Culture

(Signed) Curtis N. Hahn, M. D.
3/25, 1929 (Address) 500 Arsenal St.

*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 Mulberry Grove Ills — DATE OF BURIAL Mar 28 1929

20. UNDERTAKER Wacker Helderle — ADDRESS 2331 S. Broadway

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD