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

Do not use this space.

6987

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

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

File No. .....

Registered No. 1852

2. FULL NAME Jonas Jones

(a) Residence. No. #5 Locust St., 25 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 25 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	col.	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-3-1868

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	62	1	14	

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

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

PARENTS

10. NAME OF FATHER Prophet Jones

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT A Gertrude Creath
(Address) City Hospital #2

15. FILED FEB 21 19.. 19.. Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/17/ 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-22-, 1930, to 2-17-1930 that I last saw him alive on 2-17-1930 and that death occurred, on the date stated above, at 5 45 Am m.

I THE CAUSE OF DEATH* WAS AS FOLLOWS:

23 Chronic Myocarditis (duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (SECONDARY) Pulmonary Tuberculosis (duration) — yrs. 7 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? X-Ray

(Signed) A E Hale, M. D.

2/18/, 1930 (Address) 2945 Lawton Ave.

*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
St. Louis U	2-19 1930
20. UNDERTAKER	**ADDRESS**
Walter Richter	3500 Rutgers 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.

WRITE PLAINLY, WITH UNFADING INK

23

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