

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

Do not use this space.

20901
~~20099~~

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis Mo. (No. City..... Sanitarium)

File No.....
Registered No. 5715.
St. Ward)

2. FULL NAME

Robert L. Jones
(a) Residence. No. 5236 Waterman St., 13 Ward. (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 27 yrs. + mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Claude Jones

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 28 1864
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
65 8 15

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

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

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

14. INFORMANT..... M. R. Summers
(Address) 5300 Arsenal

15. FILED 13 1930 W. C. Markley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 12th 1930
17. I HEREBY CERTIFY, That I attended deceased from Apr. 4th 1930, 1930, to June 12th 1930, 1930 that I last saw him alive on June 11th 1930, and that death occurred, on the date stated above, at 4 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis Chronic
906
162 (duration) yrs. 2 mos. 9 ds. +

CONTRIBUTORY (SECONDARY) Senile Psychosis
(duration) yrs. 7 mos. 9 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) M. R. Summers, M. D.
6/12 1930 (Address) 5300 Arsenal

*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
Valhalla Cemetery 6-13 1930

20. UNDERTAKER ADDRESS
M. Laughlin 1631 mo. 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.

