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

Do not use this space.

791

24723

1. PLACE OF DEATH

County ..... Registration District No. 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 6882.

City ST. LOUIS MO. (No. 4438 LEE AVE. St. ..... Ward)

2. FULL NAME MATTIE JONES LEONARD.

(a) Residence. No. 4438 LEE AVE. St., 10 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 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)
FEMALE	WHITE.	WIDOWED.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10/24/1844.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	85	8	19	

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) PENN.

PARENTS

10. NAME OF FATHER WM A. JONES.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) NOT KNOWN.

12. MAIDEN NAME OF MOTHER ELIZABETH LLOYD.

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

14. INFORMANT Chas A. Parker
(Address) 4438 Lee Ave.

15. FILED JUL 14 1930 19 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JULY 13/30 19

17. I HEREBY CERTIFY, That I attended deceased from 7-13-30, 19..., to 7/13/30, 19..., that I last saw h..... alive on ....., 19..., and that death occurred, on the date stated above, at 9 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heat Prostration

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) Senility

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 30°

DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical examination

(Signed) D. L. Jennings, M. D.

, 19 (Address) 4101 Washington Blvd.

*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
BELLEFOUNTAINE CEMETERY	7/15/30 19

20. UNDERTAKER	ADDRESS
Provost Mud Co	3710 N. Grand

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.