

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.

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

Do not use this space.

NOV 15 1937

36404

1. PLACE OF DEATH

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City, **St. Louis Homer G. Phillips Hospital**..... St. (Ward)

File No.....  
Registered No. **9981**.....  
St. (Ward)

2. FULL NAME

**Infant Jones**  
(a) Residence, No. **4113 Cousins** St., **11** Ward. **1**  
(Usual place of abode)  
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **Negro** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **-**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **10-2-37**

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

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **-**  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **-**  
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

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

MOTHER FATHER  
13. NAME **Samuel Jones**

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

MOTHER FATHER  
15. MAIDEN NAME **Josephine Stamps**

16. BIRTHPLACE (CITY OR TOWN) **MISS** (STATE OR COUNTRY)

17. INFORMANT **Esther Mary Sheward** (ADDRESS) **2601 N. Whittier Street**

18. BURIAL, CREMATION OR REMOVAL PLACE **City Cemetery** DATE **10-29-37**

19. UNDERTAKER **City Health Dept.** (ADDRESS) **City Health Dept.**

20. FILED **OCT 27 1937** **J. Brebeck** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **10-2-** 19**37**

22. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at **12:24 P. M.**

The principal cause of death and related causes of importance were as follows:

**Prematurity**  
**Stillborn**  
Date of onset  
Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis? **Clinical** Was there an autopsy? **NO**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? If so, specify.....

(Signed) **Thomas C. Myrdal** M. D.  
(Address) **2601 N. Whittier**

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