

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.

REC'D AUG 12 1938

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

23759
Do not use this space.

1. PLACE OF DEATH

(a) County 2 Registration District No. 1003
(b) Township Primary Registration District No.
(c) City St. Louis, Mo (d) Street No. BARNES HOSPITAL
(e) Length of residence in city or town where death occurred yrs. 2 mos. 20 ds. (1) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 6453

2. PRINT FULL NAME Elizabeth Susie Jones

(a) Residence, No. 946 So. Main St. NR Hillsboro, Illinois
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Juan Jones

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 25/1901

7. AGE YEARS 36 MONTHS 11 DAYS 23 IF LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. housewife
10. Date deceased last worked at this occupation (month and year) Aug. 1936 11. Total time (years) spent in this occupation

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

FATHER 13. NAME Joseph Urbancsek

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Pastrick

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poland

17. INFORMANT (ADDRESS) Juan B. Jones Hillsboro, Ill.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hillsboro, Ill. DATE 7-20-38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppes, Inc. 429 N. Euclid, St. Louis

20. FILED JUL 19 1938 J. D. Budler Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-18-38 19

22. I HEREBY CERTIFY, That I attended deceased from 4-28-38, 19, to 7-18-38, 19, I last saw her alive on 7-18-38, 19, Death is said to have occurred on the date stated above, at 2:45 p.m. The principal cause of death and related causes of importance were as follows:

Cancer of breast metastasis

Date of onset

Other contributory causes of importance:

Name of operation Date of What test confirmed diagnosis? Biopsy Was there an autopsy? Yes

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) Alfred William, M. D. (Address) BARNES HOSPITAL

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

Licensed Embalmer No. 2971

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.