WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

50M-12-38 I X14028

REC'D DEC 12 1938

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

38022
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 791
(b) Township ..... Primary Registration District No. 1003 Registered No. 10349
(c) City St. Louis (d) Street No. Homer Phillips Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 24 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 576 Quintina Jones
(a) Residence, No. 4224a Fairfax Ave. St. 11
(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: Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Jasper Jones
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Year 1895
7. AGE: about YEARS 43 MONTHS unknown DAYS unknown 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)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Lamont Mississippi

FATHER
13. NAME: Tom Davis
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): UnKnown Unknown

MOTHER
15. MAIDEN NAME: Angeline-- Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Lamont Mississippi

17. INFORMANT (ADDRESS): Jasper Jones 4224a Fairfax Ave.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Washington Park DATE Nov. 30th 1938
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Chas Gates 4107 Finney Ave.
20. FILED NOV 30 1938 J. F. Bredeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 24th 1938

22. I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1938, to Nov. 24, 1938
I last saw her alive on Nov. 24, 1938 Death is said to have occurred on the date stated above, at 12:20 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Diabetes mellitus	11/14/38
Pyocellulitis of right foot (Steph Albus)	
Diabetic gangrene of rt. foot	

Other contributory causes of importance:

59

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) Richard Hachney, M. D.
(Address) 2601 N Whittier

(Licensed Embalmer's Statement on Reverse Side)

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, James A. Johnson, or by _____,

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

Signed James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 4107 Finney Avenue

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.