

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

REC'D JUN 12 1939

791
1003

16743
Do not use this space.

1. PLACE OF DEATH

(a) County..... / Registration District No.....
(b) Township..... / Primary Registration District No..... Registered No. **4277**
(c) City ST. Louis's mo. (d) Street No..... **BARNES 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Charles Turstall Jones

(a) Residence, No. 690 West Chestwood St. **NR Webster Groves mo.**
(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 **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 **Leone Rosenbaum Jones**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 26, 1873**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
65 9 10

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Pres. Capin**
9. Industry or business in which work was done, as saw mill, bank, etc. **Belt Rubber Co.**
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) **Mo. 0**

FATHER 13. NAME **Peyton C. Jones**
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ill. 1**

MOTHER 15. MAIDEN NAME **Mary A. Keck**
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mo. 0**

17. INFORMANT (ADDRESS) **Louis Jones 6234 Pershing Ave.**

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE **Calvary May 9, 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Arthur J. Donnelly 3840 Lindell Blvd.**

20. **MAY 8 1939** 19 J. B. Budeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **5-6-39** 19

22. I HEREBY CERTIFY, That I attended deceased from **4-27-39** 19, to **5-6-39** 19

I last saw h. i. m. alive on **5-6-39** 19. Death is said to have occurred on the date stated above, at **8 P.M.**

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

Brain abscess secondary to Empyema non tubercular cause unknown

Other contributory causes of importance: **none 110**

Name of operation **Craniotomy + ved** Date of **May 6**
What test confirmed diagnosis?..... 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) **Ernest Sachs**, 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 W. Van Meter

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.