

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 JUN 12 1939

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

791  
1008

17189  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. .... Registered No. **4723**  
 (c) City St. Louis or ..... (d) Street No. Homer G. 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 544 Jones

(a) Residence, No. 2031 Eugenia St. 22  
 (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 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) 5-2-39

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

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.  
 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, Mo. (STATE OR COUNTRY)

FATHER 13. NAME Clyde Jones

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

MOTHER 15. MAIDEN NAME Vera Love

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

17. INFORMANT (ADDRESS) Father Mary Shrad  
2601 N Whittier St

18. BURIAL, CREMATION, OR REMOVAL PLACE CITY CEMETERY DATE 5-25-39

19. FUNERAL DIRECTOR (NAME) Ira Hamilton (ADDRESS) City Health Dept.

20. FILED MAY 24 1939 J. B. Martin Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-2- 19 39

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 5:20 x a. m.

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

Unknown (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) J. B. Martin, M. D.  
 (Address) 2601 N Whittier St.

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**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.....

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.**