DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 20539

Registration District No. 791 — Primary Registration District No. — Registrar's No. 5383

1. PLACE OF DEATH: 1003

(a) County

(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Enroute City Hosp. #1 3 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 9

(d) Street No. 4330a Linton Street (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Robert Oscar Jones

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan. 28, 1939 (Month) (Day) (Year)

8. AGE: Years -- Months 4 Days 18 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

10. Usual occupation 0

11. Industry or business 0

FATHER
12. Name Wm. L. Jones, Jr.
13. Birthplace St. Louis (City, town, or county) Mo (State or foreign country) 0

MOTHER
14. Maiden name Bernice Hoffmeister
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature William L. Jones

(b) Address 4330a Linton Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/39 (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cem

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) JUN 17 1939 (Date received local registrar) (b) J. F. Bridick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16 year 1939 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Acute [redacted]

Due to Endocarditis

Due to Congenital Malformation Malnutrition

Other conditions (Include pregnancy within 3 months of death) (From Depravation)

Duration

Major findings: Of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

157c

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Alfred J. Perry (M. D. or other)

Address Deputy Coroner Date signed 6/17/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39 I X19311

## 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 L. R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 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.**