DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34458

Registration District No. 791 | Primary Registration District No. | Registrar's No. 8996

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: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 days (Specify whether years, months or days)

In this community Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

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(d) Street No. 2745a Wash Street
(If rural, give location)

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

3. (a) PRINT FULL NAME Monroe Jones 52

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex mal

5. Color or race col

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

6. (b) Name of husband or wife Mary

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

7. Birth date of deceased 7 (Month) 4 (Day) 1856 (Year)

8. AGE: Years 83 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Alabamber (City, town, or county) (State or foreign country)

10. Usual occupation laber

11. Industry or business

FATHER
12. Name unkown
13. Birthplace unkown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unkown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mattie Dixon

(b) Address 2326 R. Wash.

17. (a) (Burial, cremation, or removal) (b) Date thereof 10-23-39 (Month) (Day) (Year)

(c) Place: burial or cremation Father Dixon Cemetary

18. (a) Signature of funeral director Mary Wade

(b) Address 4202 Finney Ave

19. (a) OCT 23 1939 (Date received by local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 16 year 1939 hour 7:15 minute P. M.

21. I hereby certify that I attended the deceased from 10-1- 1939 to 10-16- 1939; that I last saw him alive on 10-16- 1939; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	15 days
Due to Chronic Nephritis 131	
Due to Cystitis, catarrhal	
Other conditions (Include pregnancy within 3 months of death) Prostatic Hypertrophy	

Major findings:
Of operations
Of autopsy

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

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 N. C. Young (M. D. or other)

Address 2601 N. Whittier St. Date signed 10-18-39

(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
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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 S J Watson

Licensed Embalmer No. 269 P

P. O. Address 2769 Chouteau

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.