

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.

Registration District No. 757

Primary Registration District No. 3036

Registrar's No. 161

1. PLACE OF DEATH:

(a) County St. Charles  
 (b) City or town St. Charles  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Joseph's Hospital 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 DAYS (Specify whether years, months or days)  
 In this community 2 DAYS

8. (a) PRINT FULL NAME Nasold Clemence Jones <sup>520</sup>

3. (b) If veteran, name war ✓ 3. (c) Social Security No. 488-05-9482

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 April 28 1906  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>33</u>	<u>5</u>	<u>10</u>	hr. min.

9. Birthplace Lincoln Co., Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation Maintenance

11. Industry or business Food Metal Co., St. Louis, Mo.

12. Name James William Jones

13. Birthplace Louisville, Mo.  
 (City, town, or county) (State or foreign country)

14. Maiden name Alice Cleveland

15. Birthplace Mounted, Mo.  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Bessie Schramm

(b) Address St. Charles, Mo.

17. (a) Burial (b) Date thereof Oct. 10 - 1939  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery - St. Charles, Mo.

18. (a) Signature of funeral director H. C. Ballinger & Sons Co.

(b) Address St. Charles, Mo.

19. (a) OCT 9 - 1939 (b) Clemence D. Mosler  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS  
 (c) City or town ST. LOUIS MISSOURI  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3813 WASHINGTON BLVD  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. = years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 8  
 year 39 hour 9:00 minute A M.

21. I hereby certify that I attended the deceased from Oct. 6  
 1939, to Oct 8 1939  
 that I last saw him alive on Oct 8 1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death Erysipema Duration 1 week

Due to Lobar pneumonia Type VI

Other conditions Chronic bronchitis  
 (Include pregnancy within 3 months of death)

Major findings: None  
Aspiration of chest  
 Of autopsy none

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?

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_  
 23. Signature E. J. Cartwright, M.D. (M. D. or other) \_\_\_\_\_  
 Address St. Charles, Mo. Date signed 10-9-39

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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.....

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.**