

Registration District No. 1000

Primary Registration District No. \_\_\_\_\_

Registrar's No. 10522

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis

(c) Name of hospital or institution: \_\_\_\_\_  
3815 Flad Ave.

(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

3. (a) PRINT FULL NAME Charles Fremont Jones 520

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Belle Jones

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

7. Birth date of deceased July 11, 1856

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>4</u>	<u>26</u>	hr. _____ min. _____

9. Birthplace Windsor, Ohio

(City, town, or county) (State or foreign country)

10. Usual occupation Hotel Manager and Owner

11. Industry or business \_\_\_\_\_

12. Name Samuel Jones

13. Birthplace Ohio

(City, town, or county) (State or foreign country)

14. Maiden name Catherine Harmon

15. Birthplace Pennsylvania

(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. George B. Heath

(b) Address 3815 Flad Ave.

17. (a) Removal (b) Date thereof 12-9-39

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Illinois

18. (a) Signature of funeral director Albert H. Hoppe Inc.

(b) Address 4700 Washington Blvd. 5111

19. (a) DEC 8 1939 (b) \_\_\_\_\_

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis

(If outside city or town limits, write "RURAL")

(d) Street No. 3815 Flad Ave.

(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7 year 1939 hour 6 minutes 45 P.M.

21. I hereby certify that I attended the deceased from June 1st, 1939, to Dec 7, 1939; that I last saw him alive on Dec 3, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to Cardiac

Due to arterio sclerosis

Other conditions Senility

(Include pregnancy within 3 months of death)

Duration
_____
_____
_____

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(a) Means of injury 1

23. Signature W. C. Hopewell (M. D. or other) \_\_\_\_\_

Address 585 Waterman Date signed 12/8/39

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.

**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.....

*J. S. Sullivan*

Licensed Embalmer No. 1122

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.**