

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH: **FILED MAR 12 1940**
(a) County St. Louis
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Mos. 24 Days
(Specify whether
In this community Life
years, months or days)

3. (a) PRINTED FULL NAME Irene Jones
(b) If veteran, name war ✓
(c) Social Security No. ✓

4. Sex F 5. Color or race W. 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 6-6-1896
(Month) (Day) (Year)

8. AGE: Years 43 Months 8 Days 3 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name John Jones
13. Birthplace Mo. (City, town, or county) (State or foreign country)
14. Maiden name Mary Wright
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mr. W. W. Mayfield
(b) Address 4111 Turner

17. (a) Burial (Burial, cremation, or removal) (b) Date of death Feb 9 1940
(c) Place: burial or cremation Burial Park

18. (a) Signature of funeral director J. J. ...
(b) Address 2849 N. ...

19. (a) FEB 9 1940 (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis 10 (If outside city or town limits, write "RURAL")
(d) Street No. 4111 Turner (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 9, year 1940 hour 5:45 minute _____ A.M.
21. I hereby certify that I attended the deceased from November 15, 1939 to February 9, 1940 that I last saw her alive on February 9, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis Duration _____

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
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) (e) Means of injury? _____

23. Signature W. W. Mayfield (M. D. or other) _____
Address 1515 Lafayette Date signed 2/9/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Albert Mayfield
.....

Licensed Embalmer No. *3077*

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.