

S. No. 2  
-11-10-39  
5-17-39  
P1 X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 9258  
Registrar's No. 2741

Registration District No. 791

Primary Registration District No. 1003

I. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution:  
4589 KENNERLY 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 SARAH JONES

8. (b) If veteran, name war NONE  
8. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife LATE ALBERT R. JONES  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 2nd 1859  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
80 4 20 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business HOUSEWIFE

MOTHER FATHER { 12. Name WILLIAM DILLON  
13. Birthplace U.S.  
(City, town, or county) (State or foreign country)

{ 14. Maiden name POLLY ANN SAECKLEY  
15. Birthplace U.S.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. JUANITA SPRIER

(b) Address 4589 KENNERLY AVE.

17. (c) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-25-40  
(Month) (Day) (Year)

(c) Place: burial or cremation NEW PICKERS LEM.

18. (a) Signature of funeral director W. H. ...  
(b) Address 4228 ...

19. (a) MAR 24 1940  
(Date of filing certificate)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4589 KENNERLY AVE.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22  
year 1940 hour 12 minute 45 A.M.

21. I hereby certify that I attended the deceased from March 19th 1940 to March 22 1940;  
that I last saw her alive on March 29th 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage. Duration 5 days

Due to Arterio Sclerosis. Unable  
to

Due to \_\_\_\_\_ day

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature Peter A. ... (M. D. or other)

Address 4701 S. ... Date signed 3/22/40

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

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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 Edmund M. Bernatt

Licensed Embalmer No. 3024

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.**