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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30150**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7427**

FILED OCT 27 1940

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

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town St Louis
(c) Name of hospital or institution: Homer G Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 days
In this community 16 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Lena Jones

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Arthur Jones 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 25th 1897
(Month) (Day) (Year)

8. AGE: Years 43 Months 6 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Maid

11. Industry or business Private Family

12. Name Robert Carr

13. Birthplace Fayetteville, Texas
(City, town, or county) (State or foreign country)

14. Maiden name Polly Stevenson

15. Birthplace Fayetteville, Texas
(City, town, or county) (State or foreign country)

16. (a) Informant Polly Carr
(b) Address 3922a Fairfax Avenue

17. (a) Burial (b) Date thereof 9/5/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (c) Signature of funeral director Chas. G. Sales
(b) Address 4107 Finney Avenue

19. (a) SEP 4 1940 (b) _____
(Date received local registrar)

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. 3922 a Fairfax
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31
year 1940 hour 5:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from August 15, 1940, to August 31, 1940, that I last saw her alive on August 31, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Cervix c Metastasis Apr 1 yr

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

Major findings: _____
Of operations: _____
Of autopsy: _____

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 name of place)
(c) Means of injury _____

23. Signature Barbara Smart (M. D. or other) _____
Address 2601 N Whittier Date signed _____

Duration
Physician
Underline the cause to which death should be charged statistically.

9/3/40

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.....

James A. Johnson

Registered Apprentice No.

working under my personal supervision.

Signed

James A. Johnson

Licensed Embalmer No. 3528

P. O. Address 4107 Finney Avenue

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.