No. 2
1-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

OCT 23 1940

State File No. 33095

Registration District No. 784 Primary Registration District No. 106 Registrar's No. 1947

1. PLACE OF DEATH:

(a) County: St. Louis County
(b) City or town: Kirkwood, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis Marine Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 395 days (Specify whether years, months or days)
In this community Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: St. Louis
(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4100 Enright
(If rural, give location)
(e) If foreign born, how long in U. S. A.? x years.

3. (a) PRINT FULL NAME: MACK JONES

3. (b) If veteran, name war: Unknown

3. (c) Social Security No.: Unknown

4. Sex: Male

5. Color or race: Colored

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

6. (b) Name of husband or wife: x

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

7. Birth date of deceased: July (Month) 1 (Day) 1876 (Year)

8. AGE: Years	Months	Days	If less than one day
64	3	10	hr. min.

9. Birthplace: So. Carolina (City, town, or county) (State or foreign country)

10. Usual occupation: Waiter

11. Industry or business: Str. President

MOTHER FATHER

12. Name: Allen Jones

13. Birthplace: So. Carolina (City, town, or county) (State or foreign country)

14. Maiden name: Harriet Jones

15. Birthplace: So. Carolina (City, town, or county) (State or foreign country)

16. (a) Informant: Clinical records of Marine Hosp.
(b) Address: Kirkwood, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/40 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director: C. W. Eckert
(b) Address: 3035 Lucas

19. (a) OCT 15 1940 (Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11th year 1940 hour 12:00 minute x M.

21. I hereby certify that I attended the deceased from Sept. 10th, 1940, to October 11, 1940, that I last saw him alive on October 11th, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac Disease,	
Aortic insufficiency	Unknown
Due to:	
Due to: 96	
Other conditions (Include pregnancy within 3 months of death): Aneurism Aortic Thoracic;	Unknown
Nephritis, interstitial Chronic;	
Ascites	

Major findings:
Of operations: None
Of autopsy: None

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): No
(b) Date of occurrence: x
(c) Where did injury occur? x (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? No (Specify type of place)
While at work? x (e) Means of injury: x

23. Signature: [illegible] (M. D. or other)
Address: U.S. Marine Hospital Date signed 10-11-40

(Licensed Embalmer's Statement on Reverse Side)

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 me

Chas. Lamm, Registered Apprentice No. 2349

working under my personal supervision.

Signed Chas. Lamm

Licensed Embalmer No. 2349

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.