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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 16 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33935

Registration District No. 791 | Primary Registration District No. 1003 | Registrar's No. 8632

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Childrens Hospital (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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Schuyler
(c) City or town Queencity N.R. (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Norman Lind Jones
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 Single
6. (b) Name of husband or wife Single
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 9 (Day) 1938 (Year)
8. AGE: Years 2 Months 4 Days 9 If less than one day hr. min.
9. Birthplace Queencity (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Child
11. Industry or business

FATHER
12. Name Bermie Jones
13. Birthplace Queencity (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Haley Hollowell
15. Birthplace Queencity (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Haley Jones
(b) Address Queencity, Missouri
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/19/40 (Month) (Day) (Year)
(c) Place: burial or cremation Queencity, Mo.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.
19. (a) OCT 19 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18 year 1940 hour 12 40 minute A M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Foreign Body Obstruction in Trachea
Due to (nut kernel) which child has swallowed
Due to at home in Queen City Mo
Other conditions (Include pregnancy within 3 months of death) Time and date
Major findings:
Of operations undetermined
Of autopsy Accident

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) Accident
(b) Date of occurrence Unknown
(c) Where did injury occur? Queens City Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? (e) Means of injury
23. Signature Alfred Henry (M. D. or other)
Address Deputy Coroner Date signed 10/18/40

(Licensed Embalmer's Statement on Reverse Side)

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. G. 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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.