

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34228**
8925

Registration District No. **791** Primary Registration District No. **1003**

Registrar's No.

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:
Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
(Specify whether
In this community Life
years, months or days)

3. (a) PRINT FULL NAME Mabel Jones

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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

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

7. Birth date of deceased May 14th, 1894
(Month) (Day) (Year)

8. AGE: Years 46 Months 5 Days 11 If less than one day hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business Housework

MOTHER FATHER { 12. Name Washington Vasser
13. Birthplace Unavailable Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Victoria Unavailable
15. Birthplace Unavailable Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant: Carrie Bennett
(b) Address 1504a N. Whittier St.

17. (a) Burial (b) Date thereof 10-30-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Chas. L. Finney

(b) Address 3617 Finney Ave.

19. (a) _____ (b) J. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")
(d) Street No. 1504a N. Whittier
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25
year 1940 hour 8:20 minute A. M.

21. I hereby certify that I attended the deceased from October 14, 1940, to October 25, 1940.
that I last saw her alive on October 25, 1940.
and that death occurred on the date and hour stated above.

Immediate cause of death
Pulmonary Edema
Arteriosclerosis

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy As above

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 _____

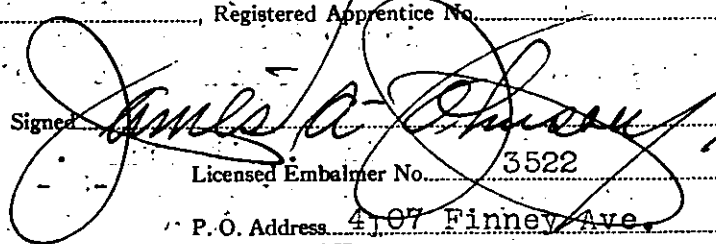
23. Signature J. W. Johnson (M. D. or other)
Address 2601 N. Whittier Date signed _____

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 _____
James A. Johnson, Registered Apprentice No. _____
working under my personal supervision.

Signed


Licensed Embalmer No. 3522
P. O. Address 4107 Finney Ave.

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.