

D. 2
13-40
7-39
X23159

FILED OCT 18 1941
791

STANDARD CERTIFICATE OF DEATH
1003

State File No. 330254
Registrator's No. 7593

Registration District No. _____

Primary Registration District No. _____

Registrator's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Peoples 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 DAW
(c) City or town Saint Louis 11 19
(If outside city or town limits, write "RURAL")
(d) Street No. 1435a North Pendleton Avenue
(If rural, give location) 8
(e) If foreign born, how long in U. S. A.? _____ years. 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 17th
year 1941 hour 1:00 minute A.M.

21. I hereby certify that I attended the deceased from _____
_____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Fracture of right leg and left wrist. Pulmonary embolus when she fell in a street and operated by one Charles M. Rogers

Other conditions: About 10:20 P.M. Aug 23, 1941 and a fall from a wheelchair at Peoples Hospital Aug 27-1941. Exact time of death unknown

Major findings: unknown
Of operations: _____
Of autopsy: no

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Aug 23 1941, Aug 27-1941
(c) Where did injury occur? St Louis Mo
(City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place (P.O.)

(Specify type of place) _____
(e) Means of injury _____
23. Signature Thomas F. Callan (M. D. or other) _____
Address 1300 Clark Avenue Date signed 9/19/1941

3. (a) PRINT FULL NAME Margaret E. Jones

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife James S. Jones 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased April 22nd 1904
(Month) (Day) (Year)

8. AGE: Years 37 Months 4 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John McClaren

13. Birthplace Unavailable Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Unavailable

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

16. (a) Informant James S. Jones

(b) Address 1435a North Pendleton Avenue

17. (a) Burial (b) Date thereof 9/20/1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director W. S. Galt

(b) Address 4107 Finney Avenue

19. (a) SEP 20 1941 (b) J. W. Budeck
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

1710
31

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

STATEMENT BY LICENSED EMBALMER

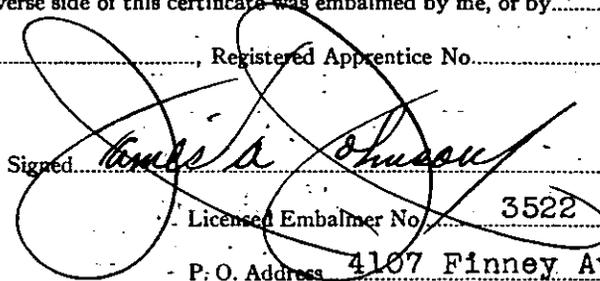
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



..... Licensed Embalmer No. 3522

..... P. O. Address 4107 Finney 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, fact should be so stated above.