

OVER DEC 9 1941
Registration District No.

Primary Registration District No. 200

2418

1. PLACE OF DEATH

(a) County St. Louis

(b) City or town Koch, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 years
(Specify whether)

In this community 28 years
years, months or days

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. 1457a Biddle
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Edward Jones

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex M 5. Color or race N 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Jan - 2 1890
(Month) (Day) (Year)

8. AGE: Years 51 Months 9 Days 18
If less than one day _____ hr. _____ min.

9. Birthplace Pine Bluff Ark 1
(City, town, or county) (State or foreign country)

10. Usual occupation Labour

11. Industry or business Miscellaneous

MOTHER FATHER { 12. Name Robert Jones 9

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Queenie Dean 9

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

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) _____ (b) Date thereof 11-11-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. H. White

(b) Address 3500 Olive St

19. (a) DEC 1 1941 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20
year 1940 hour 7 minute 05 P. M.

21. I hereby certify that I attended the deceased from March 17, 1940 to Oct. 20, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 2 yrs.

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

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) _____

(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 Robert G. Smith (M. D. or other) _____
Address Robert Koch Hospital Date signed 10/24/41

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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, fact should be so stated above.