

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4343

State File No. _____

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 288

1. PLACE OF DEATH:

(a) County Saint Louis, MO
(b) City or town Koch
(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 3 months 27 days
(Specify whether
In this community 15 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000
(c) City or town Saint Louis - MO 17
(If outside city or town limits, write "RURAL") 9
(d) Street No. 4651a EVANS
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ROBBIE LEE JONES

3. (b) If veteran, name war _____ 3. (c) Social Security No. 496-18-P406

4. Sex female 5. Color or race negro 6. (a) Single, widowed, married, divorced marital
6. (b) Name of husband or wife JAMES HENRY JONES 6. (c) Age of husband or wife if alive 23 years
7. Birth date of deceased 3 27 1920
(Month) (Day) (Year)

8. AGE: Years 23 Months 10 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace GADSDEN Alabama
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name MILTON JONES

13. Birthplace JACKSONVILLE Alabama
(City, town, or county) (State or foreign country)

14. Maiden name BEATRICE WILLIAMS

15. Birthplace JACKSONVILLE Alabama
(City, town, or county) (State or foreign country)

16. (a) Informant Bernard Robert Koch Hospital

(b) Address KOCH - MO

17. (a) BURIAL (b) Date thereof 2-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WASHINGTON PARK

18. (a) Signature of funeral director C. W. ROBERTS

(b) Address 1416 N. TAYLOR AVE

19. (a) FEB 7 - 1944 (b) E. G. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 2nd
year 1944 hour 4 minute 50 P. M.

21. I hereby certify that I attended the deceased from 10-5-1943 19 to 2-2-44 19
that I last saw him alive on 2-2-44 19
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Pulmonary Tuberculosis Duration 1 year?

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy 1361

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 Bernard Friedman (M. D. or other) MD

Address Koch Hosp, Koch, MO Date signed 2-3-44

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

96
00

MOTHER FATHER

MAR 2 9 1944

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 Fulton G. Culkin

Licensed Embalmer No. 4198

P. O. Address St. Louis 13, Mo.

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.