. S. No. 2
DM—8-43
v. 5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 30 1944 318

Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 36044

Registrar's No. 9845

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:
St. Louis Children's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution? 0 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 1845 N. Washington
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Raymond Corbin Jones
3. (b) If veteran, name war Nil
3. (c) Social Security No. Nil
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased September (Month) 27 (Day) 1938 (Year)

8. AGE: Years	Months	Days	If less than one day
6	1	20	hr. min.

9. Birthplace Springfield (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation Child
11. Industry or business
FATHER 12. Name Roy Jones
13. Birthplace Springfield (City, town, or county) Missouri 0 (State or foreign country)
MOTHER 14. Maiden name Evelyn Griffith
15. Birthplace St. Joseph (City, town, or county) Missouri 0 (State or foreign country)
16. (a) Informant Mrs. Roy Jones
(b) Address Springfield, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-18-44 (Month) (Day) (Year)
(c) Place: burial or cremation Springfield, Mo.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) NOV 24 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17 year 1944 hour 10 minute 10 A.M.
21. I hereby certify that I attended the deceased from 10-23, 1944, to 11-17, 1944; that I last saw him alive on 11-17, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchiectasis	
Lung Abcess 2nd Atelectasis	2 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

106

Major findings:
Of operations Bronchiectasis Atelectasis
Of autopsy Bronchiectasis, Atelectasis Lung Abcess

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature H. H. Hoppe Gilbert B. Forbes (M. D. or other) MD
Address 500 South Kingshighway Date signed

(Licensed Embalmer's Statement on Reverse Side)

9845

9845

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 John W Ogonowski

Licensed Embalmer No. 2398

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.