. S. No. 2
M—8-43
5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 9 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36046
Registrar's No. 10132

Registration District No. ____ Primary Registration District No. ____

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: 6630A Alabama Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)
In this community 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 1 17 9
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 6630A Alabama Ave.
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Vera Jones
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex Female
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 Apr. (Month) 5 (Day) 1878 (Year)

8. AGE: Years	Months	Days	If less than one day
66	7	21	____ hr. ____ min.

9. Birthplace Salisbury (City, town, or county) Mo. (State or foreign country)
10. Usual occupation None
11. Industry or business ____
FATHER 12. Name George Cl Jones
FATHER 13. Birthplace ____ (City, town, or county) Mo. (State or foreign country)
MOTHER 14. Maiden name Sarah E. Ryan
MOTHER 15. Birthplace ____ (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Mrs. J. E. LeFaivre
(b) Address 6630A Alabama Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-44 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla
18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.
19. (a) NOV 28 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26 year 1944 hour 10 minute 45 P.M.
21. I hereby certify that I attended the deceased from May 12, 1944, to Nov. 26, 1944 that I last saw him alive on Nov 26, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to	
Due to Hypertension	10 yrs
Other conditions (Include pregnancy within 3 months of death) none	

Major findings:
Of operations none
Of autopsy no

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) no
(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 H. [illegible] (M. D. or other) M.D.
Address 4703 Virginia Date signed 11-28-44

(Licensed Embalmer's Statement on Reverse Side)

Dr. H.J. Sherwin
4703 Virginia Ave.
1:30 to 3:30

Lic 7950

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 Warren G. Carver

Licensed Embalmer No. 3534

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.