

No. 2  
1-5-43  
5-17-39  
1 X36871

FILED DEC 29 1944 318

Primary Registration District No. 1003

Registrar's No. 10846

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hours, 50 minutes  
(Specify whether)

In this community 18 hrs. 35 minutes  
(years, months or days)

3. (a) PRINT FULL NAME Clifford Jones Jr.

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased November 19, 1944  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	<u>18</u> hr. <u>35</u> min.

9. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Clifford Jones Sr.

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

14. Maiden name \_\_\_\_\_

15. Birthplace Sodie Yerler  
(City, town, or county) (State or foreign country)

16. (a) Informant Shirley M. Smith Miss.

(b) Address 2601 N. Whittier

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof DEC 21 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director W. B. Hudson

(b) Address City Health Dept

19. (a) DEC 20 1944 (Date received local registrar) J. F. Bedek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **10846**

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")

(d) Street No. 1012a N. Newstead  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 19,  
year 1944 hour 10 minute 05 P. M.

21. I hereby certify that I attended the deceased from November  
19, 19 44 to November 19, 19 44  
that I last saw h in alive on November 19, 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 D

23. Signature W. D. Linkler (M. D. or \_\_\_\_\_)  
Address 2601 Whittier Date signed 12/21/44

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**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.**