U. S. No. 2
OM—9-4-41
Rev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 29 1945

Registration District No. 317

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3069

State File No. 3450

Registrar's No. 2735

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Richmond Hights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community: 0

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: St. Louis

(c) City or town: Wellston
(If outside city or town limits, write "RURAL")

(d) Street No.: 2305 Kienlen Ave.,
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: Ronald Jones

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

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: July 31, 1944 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
0	5	5	..... hr. ..... min.

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

10. Usual occupation: None

11. Industry or business .....

FATHER
12. Name: Raymond Jones
13. Birthplace: Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Bernice Noel
15. Birthplace: Missouri (City, town, or county) (State or foreign country)

16. (a) Informant: L.F.Morrison
(b) Address: 6715 Bartmer Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 6/45. (Month) (Day) (Year)
(c) Place: burial or cremation: Old St. Peter & Paul Cem.,

18. (a) Signature of funeral director: Jos. W. Clark
(b) Address: 1125 Hodiamont Ave.,

19. (a) JAN 8 1945 (Date received local registrar) (b) E. G. McLaurin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 5 year 45 hour 12 minute 55 A.M.

21. I hereby certify that I attended the deceased from 7-10, 1944, to 1-5, 1945, that I last saw him alive on 1-4, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Marasmus.

Due to: Celiac Disease.

Due to .....

Other conditions (Include pregnancy within 3 months of death): 0

Major findings:
Of operations .....
Of autopsy: Granted but not performed yet.

Duration

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: [illegible] (M. D. ~~or other~~)
Address: 634 N. Grand Date signed 1-8-45

(Licensed Embalmer's Statement on Reverse Side)

Dr. P.G. Davis
634 N. Grand Blvd.,
JE. 5055

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 Jos. W. Clark

Licensed Embalmer No. 1661

(No Embalming)

P. O. Address 1125 Hodiamont Ave.,

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.