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7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUN 4 1945 18

L 1003

Registration District No.

Primary Registration District No.

Registrar's No.

542
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17
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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:
2608 N. Taylor Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 2 years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2608 N. Taylor Avenue
(If rural, give location)
(e) Citizen of foreign country? !! (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Charles Jones
3. (b) If veteran, name war no
3. (c) Social Security No.....

4. Sex Male 9 5. Color or race Negro
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 Mar. 17, 1903
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 2 3 hr. min.

9. Birthplace Tallula Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business.....

12. Name Charles Jones
13. Birthplace Tallula Miss.
(City, town, or county) (State or foreign country)
14. Maiden name Fannie Davis
15. Birthplace Tallula Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Lonnie Jones
(b) Address 716 N. Jafferson

17. (a) Burial (b) Date thereof May 25, 45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park,

18. (a) Signature of funeral director Dement & Son
(b) Address 2629-31 Cole Street

19. (a) MAY 22 1945 (b) J. F. Brudeck
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 20th day May
year 1945 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1st
March, 1945 to May 20th, 1945
that I last saw him alive on May 20th, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis
acute

Due to unknown to cause of Ac Myo,

Due to of ca
Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations no
Of autopsy no

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) (r) Means of injury
23. Signature J. T. Edwards (M. D. or other)
Address 1906 W. 7th Date signed 5-22-45

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

MOTHER FATHER

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..... *W. Claude Gordon*.....

Licensed Embalmer No..... *3489*.....

P. O. Address..... *457 5th Avenue*.....

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.