V. S. No. 2
00M—5-43
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9 1945 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15253
Registrar's No. 4626

Registration District No. ..... Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St
(b) City or town Sty Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1815 Franklin Ave
(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 .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 000 17 021
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1815 r. Franklin Ave
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME JOHN WILEY JONES
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Nettie Jones
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased October (Month) 19 (Day) 1863 (Year)

8. AGE: Years 81 Months 7 Days 4 If less than one day ..... hr. ..... min.

9. Birthplace Arkansas (City, town, or county) (State or foreign country)
10. Usual occupation Unemployed
11. Industry or business .....

FATHER
12. Name John Jones
13. Birthplace Arkansas (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Arkansas (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nettie Jones
(b) Address 1851 r. Franklin Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/45 (Month) (Day) (Year)
(c) Place: burial or cremation New Picker Cemetery
18. (a) Signature of funeral director Central Und Co.
(b) Address 1841 Cass ave
19. (a) MAY 25 1945 (Date received local registrar) (b) J. T. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23rd year 1945 hour 7 minute 40 A.M.
21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...; that I last saw h. ..... alive on ....., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Following a altercation in which he was injured from blows of his fireman's club on the 18th Northern Ave. and the deceased was struck with a [illegible] in the hands of one Glenn Strickland Col. Wounded 7:30 A.M. May 23 1945
Whether the results of Malicious Cause the altercation could not be determined
Duration .....
Other conditions (Include pregnancy within 3 months of death) .....
Major findings:
Of operations .....
Of autopsy .....

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) Gun Verdict
(b) Date of occurrence May 23 1945
(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? Home
(Specify type of place)
While at work? ..... (e) Means of injury a bullet

23. Signature Patrick R. Reilly (M.D. or other)
Address ..... Date signed 5/26/45

(Licensed Embalmer's Statement on Reverse Side)

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 Ogonowski

Licensed Embalmer No. 3398

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.