

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18882

State File No.

FILED JUN 19 1945

Registration District No.

818

Primary Registration District No.

1003

Registrar's No.

4980

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... St. Louis, Mo.
 (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..... 8 days
 (Specify whether
 In this community..... 4 years
 years, months or days)

3. (a) PRINT FULL NAME Virginia Jones

3. (b) If veteran, name war..... none
 3. (c) Social Security No. ?

4. Sex Female, race colored
 5. Color or race.....
 6. (a) Single, widowed, married, divorced, widow
 6. (b) Name of husband or wife..... S.S. Jones, deceased,
 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased Dec 26th, 1882.
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 5 5
 hr. min.

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

10. Usual occupation..... Unemployed,11. Industry or business..... Domestic,12. Name Dan Kahee,13. Birthplace..... Mississippi
 (City, town, or county) (State or foreign country)14. Maiden name..... Alice Johnson,15. Birthplace..... N. Carolina.
 (City, town, or county) (State or foreign country)16. (a) Informant..... Floa Griffiths(b) Address..... 2715a Franklin Ave, St Louis, Mo.17. (a) Burial (b) Date thereof 6-6-45
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation..... Washington Ave18. (a) Signature of funeral director..... [Signature](b) Address..... 2812 Thomas St19. (a) JUN 5 1945 (b) J. F. Bridges
 (Date received local registrar) (Registrar's signature)

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..... 2318 Cole
 (If rural, give location)
 (e) Citizen of foreign country?..... No
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31,
 year..... 1945 hour..... 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from..... May
23, 1945, to..... May 31, 1945.

that I last saw her..... alive on..... May 31, 1945.
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Chr. Nephritis with Uremia

Duration
Undet.

Due to.....

Due to.....

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:

(c) 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)
 (c) Means of injury.....

23. Signature..... B. F. Murphy (M. D. or other)Address..... 300 W. 11th St Date signed..... 6/1/45

STATEMENT BY LICENSED EMBALMER

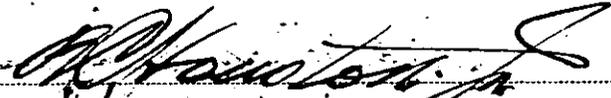
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

myself,

....., Registered Apprentice No.

working under my personal supervision.

Signed



.....
-Licensed Embalmer No. 2266.....

P.O. Address 2812 Thomas, St, StLouis,

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.