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DM—8-43
ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25016

FILED AUG 7 1945

Registration District No. 6076 Primary Registration District No. 6076 Registrar's No. 2576

1. PLACE OF DEATH:
(a) County: St Louis
(b) City or town: Koch (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch O (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 6 mths 23 days (Specify whether years, months or days)
In this community: 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: 000
(c) City or town: St Louis 17 (If outside city or town limits, write "RURAL")
(d) Street No.: 717 N. Leonard 9 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: —

3. (a) PRINT FULL NAME: Herbert Jones
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: yes
4. Sex: M
5. Color or race: N
6. (a) Single, widowed, married, divorced: M 1
6. (b) Name of husband or wife: Tillie Jones
6. (c) Age of husband or wife if alive: ? years
7. Birth date of deceased: 3 (Month) - 31 (Day) - 86 (Year)
8. AGE: Years 58 Months 7 Days 20 If less than one day ___ hr. ___ min.
9. Birthplace: Mc Kenzie (City, town, or county) Tenn 1 (State or foreign country)
10. Usual occupation: Porter
11. Industry or business: —
FATHER
12. Name: Hilry Jones
13. Birthplace: Mc Kenzie (City, town, or county) Tenn 1 (State or foreign country)
MOTHER
14. Maiden name: Betty Carson
15. Birthplace: Mc Kenzie (City, town, or county) Tenn 1 (State or foreign country)
16. (a) Informant: Hospital Record
(b) Address: Robert Koch Hosp, Koch, Mo
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12-21-44 (Month) (Day) (Year)
(c) Place: burial or cremation: City Crematory
18. (a) Signature of funeral director: Jas Ryan
(b) Address: 5700 Laclede St
19. (a) 12/23/44 (Date received local registrar) (b) E. L. McGavran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 20 year 44 hour 7 minute 45 A.M.
21. I hereby certify that I attended the deceased from 4-28-1944 to 11-20-1944 that I last saw him alive on 11-20-1944; and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 4 yrs (?)
Due to: 1351
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:
(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: A H Bonner (M. D. or other)
Address: Robert Koch Hosp, Koch Mo Date signed 11-20-44

(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.....

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.