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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 25 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32032

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9045

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:
CITY ISOLATION HOSPITAL.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2/7/45 to 10/12/45 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COUNTY 96

(c) City or town WEBESTER GROVES
(If outside city or town limits, write "RURAL")

(d) Street No. 115 RAVIN AVE NR 74
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME MOLLIE JONES

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FEMALE 3

5. Color or race COLORED

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband ~~or wife~~ Frank Jones

6. (c) Age of husband or wife if alive years

7. Birth date of deceased JULY, 1865
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days If less than one day hr. min.

abt

9. Birthplace unknown 7
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name WICKS
13. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name BESTY
15. Birthplace UNKNOWN 6
(City, town, or county) (State or foreign country)

16. (a) Informant CITY INFIRMARY RECORDS.
(b) Address 5800 ARSENAL ST.

17. (a) Burial (b) Date thereof 10-20 45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director J C Lewis
(b) Address 22 Euclid Ave Webster - Grove

19. (a) OCT 19 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 12
year 1945 hour 8:30 minute P M.

21. I hereby certify that I attended the deceased from 2/7 1945, 1945, to 10/12, 1945
that I last saw her alive on 10-12, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Vascular Accident	
Generalized Arterio Sclerosis	1945+
Due to Arterio Sclerotic Gangrene of Left Toes	1945+
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 83

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 Palmer Romaine Bowdish (M. D. or other)

Address 5300 Arsenal Date signed

(Licensed Embalmer's Statement on Reverse Side)

MAY 15 1946

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 J. C. Lewis

Licensed Embalmer No. 2027

P. O. Address Webster Groves

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.