

S. No. 2
 M-2-43
 7-5-17-39
 No 1 X35697

34635

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

State File No. _____
 Registrar's No. 2545

FILED NOV 10 1945
 Registration District No. 317

Primary Registration District No. 3063

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

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis County Hospital 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 days
(Specify whether years, months or days)
 In this community 28 Years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis 9/6
 (c) City or town Valley Park 16
(If outside city or town limits, write "RURAL")
 (d) Street No. Meramec Canoe Club 0
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME NEWTON JONES

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

4. Sex Male 0
 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Rose Griffith
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 28 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	1	8	hr. _____ min.

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

10. Usual occupation Caretaker

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Jones

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

14. Maiden name Sarah Ogle

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

16. (a) Informant Grace Palmer

(b) Address Valley Park, Mo.

17. (a) _____ (b) Date thereof Nov. 7 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reedville Cem. Sullivan Mo.

18. (a) Signature of funeral director Schrader Funeral Home

(b) Address Ballwin Mo.

19. (a) 11-6-45 (b) E. J. McFarland
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day Fifth
 year 1945 hour Four minute 10 AM.

21. I hereby certify that I attended the deceased from October 29th, 1945 to November 5th, 1945, that I last saw him alive on November 5th, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage from lenticles - 2 wks. to striate artery

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:

(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? No.

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature Wm. W. Carter M.D. (M.D. or other)
 Address 607 Crestwood, Clayton Date signed 11-5-45

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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

Geo. Schrader

Licensed Embalmer No.

3066

P.O. Address

Bellewin, Mo.

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.