

S. No. 2  
M-5-43  
5-17-39  
1 X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35451

State File No. \_\_\_\_\_

FILED DEC 7 1945  
318

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003 Registrar's No. 10335

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(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 1 Hr. 35 Mins.  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

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. 4253 (R) West Evans  
(If rural, give location) \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Infant Jones  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 11 day 13  
year 1945 hour 3 minute 35 A. M.  
21. I hereby certify that I attended the deceased from 2:00 A. M.  
11 - 13, 1945 to 3:35 A. M. 11-13, 1945  
that I last saw him alive on 11-13, 1945  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Negro  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased. 11 13 45  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Prematurity  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 1 hr. 35 min.  
9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name Cornelius Prentice Jones  
13. Birthplace Grapeland Mississippi  
(City, town, or county) (State or foreign country)  
14. Maiden name Geraldine Scales  
15. Birthplace Granada Mississippi  
(City, town, or county) (State or foreign country)

16. (a) Informant Walter M. Sheward, R.H.D.  
(b) Address 2601 N. Whittier Street  
17. (a) Buried (b) Date thereof NOV 29 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation CITY CEMETERY

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? \_\_\_\_\_

18. (a) Signature of funeral director V. B. Hudson  
(b) Address City Health Dept.  
19. (a) NOV 29 1945 (b) J. F. Brebeck  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature William H. Hubert  
Address 2601 N. Whittier Date signed 11-24-45

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

MOTHER FATHER

---

---

**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.**