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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39338

FILED JAN 31 1946

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 11137

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)

In this community 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 17

(c) City or town St. Louis 326
(If outside city or town limits, write "RURAL")

(d) Street No. 3312a No. 11th
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME BABY GIRL JONES (2)

3. (b) If veteran, name war ---

3. (c) Social Security No. ---

4. Sex Female 1

5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased December 12th, 1945 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 2 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis City Hospital (City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

FATHER
12. Name Raymond
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Grace
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12-20-45 (Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director W. J. White Jr.
(b) Address City Hospital 101

19. (a) DEC 20 1945 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 14th year 1945 hour 11:15 minute A M.

21. I hereby certify that I attended the deceased from 12/12/45, 19__, to 12/14/45, 19__; that I last saw her alive on 12/14/45, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity — Duration

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? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature George N. Donnelly (Coroner or other)

Address 1015 Lafayette Date signed 12/15/45

(Licensed Embalmer's Statement on Reverse Side)

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

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.