

FILED APR 5 1948 STANDARD CERTIFICATE OF DEATH

11289

State File No.

2893

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No.

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:
Honer G Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 days**
(Specify whether years, months or days)
 In this community _____

3. (a) PRINT FULL NAME **Cleo Jones**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **Negro** 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 **Mar. 23 1945**
(Month) (Day) (Year)

8. AGE: Years _____ Months **11** Days **13** If less than one day hr. _____ min. **0**

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

10. Usual occupation _____

11. Industry or business _____

12. Name **Joseph Mayfield**

13. Birthplace **Unk**
(City, town, or county) (State or foreign country)

14. Maiden name **Nettie Jones**

15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Elizabeth Hardiman**
2601 N Whittier

(b) Address _____

17. (a) **Burial** (b) Date thereof **MAR 28 1948**
(Burial, cremation, or removal) (City or town) (County) (State) (Day) (Year)

(c) Place: burial or cremation **CITY CEMETERY**

18. (a) Signature of funeral director **V. B. Hudson**

(b) Address **City Health Dept**

19. (a) **MAR 28 1948** (b) **J. F. Braseck**
(Date of death) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
 (c) City or town **St. Louis** **25 17**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1610 CASS**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar.** day **5**
 year **1946** hour **2** minute **10 P** M.

21. I hereby certify that I attended the deceased from **3-2** 19**46**, to **3-5** 19**46**
 that I last saw her alive on **3-5** 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia - Primary**

Due to _____

Due to **107**

Other conditions **107**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy: **Yes**

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 **0**

23. Signature **C. Naveck** (M. D. or other) **0**
 Address **2601 N Whittier** Date signed **3/21/46**

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

10201

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.