

S. No. 2  
M-5-43  
5-17-39  
I X38671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25402  
6328  
Registrar's No.

FILED JUL 26 1946  
Registration District No.

Primary Registration District No.

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

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: St. Louis Children's  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 days  
In this community 10 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County ooc  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5524 Easton  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Dwain Franklin Jones

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

4. Sex male 5. Color or race white  
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. 12 14 41  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
4 7 3 hr. min.

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

10. Usual occupation none

11. Industry or business.....

12. Name Otto Jones

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

14. Maiden name Mariam Shehane

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

16. (a) Informant Otto Jones

(b) Address 5524A Easton Ave.

17. (a) Burial (b) Date thereof 2-22-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 5524 Easton Ave.

19. (a) JUL 18 1946 (b) J. F. Bredeek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 17  
year 46 hour 3 minute 25 A.M.

21. I hereby certify that I attended the deceased from 7-7- 1946 to 7-17- 1946;  
that I last saw him alive on 7-17-46, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
medulla oblongata cerebellum  
Due to.....  
Due to.....  
Other conditions.....  
(Exclude pregnancy within 3 months of death)

Duration  
PHYSICIAN

Major findings:  
Of operations.....  
Of autopsy medulla oblongata cerebellum  
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..... (c) Means of injury.....

23. Signature George E. Rouelai (M. D. or other) MD  
Address 5518 Pershing Date signed.....

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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..... *Albert R. Thompson Jr.*.....  
..... Licensed Embalmer No. *42137*.....  
..... P. O. Address..... *St. Louis*.....

**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.**