

FILED OCT 23 1946

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

34543

1. PLACE OF DEATH

County St. Charles
Township
City St. Charles (No. _____)

Registration District No. 310
Primary Registration District No. 3059

File No. _____
Registered No. 159
St. _____ Ward

2. FULL NAME

Bobby Ray Jones

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 1

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-9-1946

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 23 hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) St. Charles, Mo. (STATE OR COUNTRY)

13. NAME Robert Cecil Jones

14. BIRTHPLACE (CITY OR TOWN) St. Charles Co., Mo. (STATE OR COUNTRY)

15. MAIDEN NAME Luella Emma Dieckhaus

16. BIRTHPLACE (CITY OR TOWN) Duetzow, Mo. (STATE OR COUNTRY)

17. INFORMANT Robert Jones (ADDRESS) 1711 Park St. Charles, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Burial DATE Oct 11, 1946

19. UNDERTAKER Wachmann & Sons (ADDRESS) St. Charles, Mo.

20. FILED 10/18/46 19 1946 Jamie Hamilton Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 10, 1946

22. I HEREBY CERTIFY, That I attended deceased from 10/9/46, 1946, to 10/10/46, 1946. I last saw h. alive on 10/10/46, 1946. Death is said to have occurred on the date stated above at 1:30 A.M.

The principal cause of death and related causes of importance were as follows:

Respiratory Failure
Premature Birth
Date of onset 1 day

Other contributory causes of importance:
157

Name of operation None Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? 0
If so, specify _____
(Signed) R. J. Budice, M. D.
(Address) 126 S. Main St.

OCCUPATION
FATHER
MOTHER

~~Date Filed 10-22-46~~

~~District File Number~~

District Health Officer No. 9,

RECEIVED

Registration District No. 310

Primary Registration District No. 3058

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Robly R Jones
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased Oct 9 (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ year 1946 (hour) _____ minute 30 a.m.
21. I hereby certify that I attended the deceased from 10/9/46 to 10/10/1946
that I last saw him/her alive on 10/10/1946
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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? _____

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

23. Signature R. R. Hudle (M. D. or other)
Address 126 S. Main St. Date signed 10/29/46

SUPPLEMENTARY

MOTHER FATHER

USE UNFADING BLACK INK - MAKE A LEGAL COPY

34543

K. H. H. /
2.5.20

1.1.1.1