

No. 2
-12-45
5-17-39
1 X47070

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.

(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..... (Specify whether)

In this community..... (Yes or No)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 904 So. 18th.
Memorial (If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME MINNIE JONES

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased March 28 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>0</u>	<u>12</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name Unknown

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

14. Maiden name Unknown Mallone

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-47
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) APR 11 1947 (Date received local registrar) (b) Jet Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10th
year 1947 hour 6:52 minute A M.

21. I hereby certify that I attended the deceased from 1/3/47
..... 19..... to April 10th, 19 47
that I last saw her alive on April 10th, 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia of rib
fract
intercostal

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death).....

Major findings:
Of operations not done

Of autopsy not done

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 1515 Lafayette (Date signed) 4/10/47
Address.....

*Very faint
Rec'd
May 5, 1911*

No Embalm

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..... **No Embalm**

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.