S. No. 2
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19000

FILED JUN 5 1947

#994 Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5263

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

1. PLACE OF DEATH:

(a) County

(b) City or town St.Louis,Mo.
(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 1 week (Specify whether years, months or days)

In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 3500 No. Florrisant Bl.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME WILLIAM JONES

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Ellen

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

7. Birth date of deceased December 30, 1874 (Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 25 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name John Jones
13. Birthplace ? (City, town, or county) Missouri (State or foreign country)

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

16. (a) Informant Maude Weisbrod
(b) Address 4085 Wilmington Ave

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 5-28-47 (Month) (Day) (Year)
(c) Place: burial or cremation City Cem.Pacific,Mo.

18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 2301 Lafayette Ave

19. (a) MAY 27 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25th year 1947 hour 10:45 minute A M.

21. I hereby certify that I attended the deceased from 5/19/47, 19, to May 25th,1947 19; that I last saw him alive on May 25th,1947 19; and that death occurred on the date and hour stated above.

Immediate cause of death hemorrhage ~~cerebr~~ cerebral from lenticulostriate artery

Due to arteriosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Same

Duration

PHYSICIAN

Underline the cause of 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 M.Hara (M. D. or other)

Address 1515 Lafayette Date signed 5/26/47

M.Hara

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 L R Cooper

Licensed Embalmer No. 3633

P. O. Address 230 Lafayette Ave

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.