

FILED JUN 30 1947
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Registration District No. _____ Primary Registration District No. _____ Registrar's No. **5479**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **Saint Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital
(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 **John R. 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** **Married**
6. (b) Name of husband or wife **Katherine Jones** **6. (c) Age of husband or wife if alive** **67** years
7. Birth date of deceased **Sept. 7, 1876**
(Month) (Day) (Year)

8. AGE: Years **70** Months **8** Days **16** If less than one day _____ hr. _____ min.

9. Birthplace **Wales** **4**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired actor.**

11. Industry or business **Managed his property**

MOTHER FATHER
12. Name **William Jones**
13. Birthplace **Wales** **4**
(City, town, or county) (State or foreign country)
14. Maiden name **not known**
15. Birthplace **not known** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Katherine Jones**
(b) Address **4533 Westminster**

17. (a) Cremation **(b) Date thereof** **May 24, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Missouri Crematory**

18. (a) Signature of funeral director **Craig Mortuary**
(b) Address **4468 Washington-8-**

19. (a) **MAY 24 1947** **(b)** **J. F. Bredich**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **Saint Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **4533 Westminster** **9**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **23** year **1947** hour **6:02** minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death. **Cardiac hypertrophy;**
Generalized Arterio Sclerosis;
enility.

Due to _____
Due to _____ **95**
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)
Means of injury **3**
23. Signature **Alfred J. Perry** (M. D. or other)
Address **Edity Brown** Date signed **5/24/47**

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

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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.....

NO EMBALMING

....., 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.