S. No. 2
M—1/47
r. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42924

FILED DEC 22 1947

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 11389

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: Homer G. Phillips Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)
In this community

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. 3111 Laclede (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Josh Cones
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race Col.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Carrie Cones
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 2 (Day) 1893 (Year)

8. AGE: Years 54 Months 9 Days 9 If less than one day hr. min.

9. Birthplace Camden (City, town, or county) Miss. (State or foreign country)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Jack Cones
13. Birthplace unknown (City, town, or county) (State or foreign country)

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

16. (a) Informant Carrie Cones
(b) Address 3111a. Laclede Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/47 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cemetery
18. (a) Signature of funeral director Ellis Funeral Home
(b) Address 2820 Stoddard St.
19. (a) DEC 13 1947 (Date received local registrar) (b) J. T. Broderick (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 11 year 1947 hour 3 minute 5 a. M.
21. I hereby certify that I attended the deceased from Dec. 6, 1947 to Dec. 11, 1947 that I last saw him alive on Dec. 11, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Sibarachnoid Hemorrhage	
Arteriosclerotic Heart Disease with Decompensation	Undet.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Pleural Effusion	

Major findings:
Of operations
Of autopsy No

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 Oscar L. Daniels (M. D. or other)
Address 2601 N Whittier Date signed 12/11/47

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 Fulton E. Culkin

Licensed Embalmer No. 498

P. O. Address St Louis 13. Mo.

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.