No. 2
1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3517

FILED JAN 17 1948

Registration District No. 3 7

Primary Registration District No. 6076

Registrar's No. 96

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 913 days (Specify whether
In this community 4½ years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1607 Carver Lane 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME JONES, ESTHER LEE
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lee Jones
6. (c) Age of husband or wife if alive years
7. Birth date of deceased August (Month) 1 (Day) 1920 (Year)

8. AGE: Years 27 Months 5 Days 8 If less than one day hr. min.

9. Birthplace Clarksdale (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Giles Harris
13. Birthplace (City, town, or county) Mississippi (State or foreign country)
MOTHER
14. Maiden name Hannah Henderson
15. Birthplace (City, town, or county) Mississippi (State or foreign country)
16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital
17. (a) (Burial, cremation, or removal) (b) Date thereof 1 15 48 (Month) (Day) (Year)
(c) Place: burial or cremation NATIONAL CEM JEFF BARRICK
18. (a) Signature of funeral director A. F. Walton
(b) Address 2707 Staddard St
19. (a) 1-12-48 (Date received local registrar) (b) Cecil C. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9
year 1948 hour 2 minute 55 P. M.
21. I hereby certify that I attended the deceased from 7-10-45 19 to 1-9-48 19;
that I last saw her alive on 1-9-48 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	13 yrs. (??)
Due to 13b	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 0
23. Signature William C Banton II (M. D. ~~or other~~)
Address Robert Koch Hospital Date signed 1/10/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

JAN 17 1948

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard 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.