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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 8 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38285

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9559

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:
1541 Marcus Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community Life

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. 1541 Marcus Avenue
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Alvin Norman Jones

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 31 (Day) 1948 (Year)

8. AGE: Years | Months 5 | Days 12 | If less than one day hr. min.

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

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name Samuel H. Jones
13. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elaine Larkin
15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Samuel Jones
(b) Address 1541 Marcus Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Avenue

19. (a) NOV 16 1948 (Date received local registrar) J. B. Lechner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 13th year 1948 hour 8 1 minute 50 P. M.

21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw him alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Anterior Poliomyelitis
Antecedent Respiratory Paralysis
Due to Myasthenia Gravis Generalized
Due to Myasthenia

Other conditions (Include pregnancy within 3 months of death) 110

Major findings: Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Fabrick E. Taylor (M. D. or other)

Address 1300 Clark Avenue Date signed 11-16-48

(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

John K. Cunningham, Registered Apprentice No.

working under my personal supervision.

Signed John K Cunningham

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.