V.S. No. 300
Rev. 10-48

FILED MAY 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17393

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4320

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 8 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3520a Clark Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 3520a Clark Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Robert
b. (Middle): William
c. (Last): Jones

4. DATE OF DEATH (Month) (Day) (Year): May 12, 1949

5. SEX: Male 2
6. COLOR OR RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 15, 1865
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months 5, Days 27 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Jackson County, Ark.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: Abraham Jones
13b. MOTHER'S MAIDEN NAME: Angeline ?
14. NAME OF HUSBAND OR WIFE: Priscilla Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Ray Jones — ADDRESS: 2945 Franklin Avenue

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chr. Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertensive Heart Disease — 3
DUE TO (c): Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [ ] No [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? 443X

22. *I hereby certify that I attended the deceased from* Mar 20th, 1949, *to* May 12, 1949, *that I last saw the deceased alive on* May 12, 1949, *and that death occurred at* 2:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): S. R. Barrett M.D.
23b. ADDRESS: 2835a Easton Ave.
23c. DATE SIGNED: 5-13-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: May 17, 1949
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State): Tuckerman, Arkansas

DATE REC'D BY LOCAL REG.: MAY 15 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR'S SIGNATURE: G. B. Koonce — ADDRESS: 1221 N. Grand Blvd

(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 _____

_____ Student Embalmer No. _____,

working under my personal supervision.

Student _____
Student Embalmer

Signed Theodore E. Cooper

Licensed Embalmer No. 4600

P. O. Address 1281 S. Grand

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.