

FILED MAR 26 1949

STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 10231
Registrar's No. 2463

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY <i>Mad</i>	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 4104 Enright Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer Phillips <i>0</i>			

3. NAME OF DECEASED (Type or Print) Florence M Jones			4. DATE OF DEATH (Month) (Day) (Year) March 17, 1949		
5. SEX Female <i>3</i>		6. COLOR OR RACE - Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married <i>1</i>	
8. DATE OF BIRTH 1-20-1889		9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Service Worker		10b. KIND OF BUSINESS OR INDUSTRY Hosp.		11. BIRTHPLACE (State or foreign country) St. Louis, Mo. <i>0</i>	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Clarence Renacker		13b. MOTHER'S MAIDEN NAME Florence Hays		14. NAME OF HUSBAND OR WIFE Robert J. Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert J. Jones 4104 Enright	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fatty Metamorphosis of the Liver		DUPLICATE			Undet.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			Undet.	
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				
		DUE TO (b) Cholemia				
		DUE TO (c) None				
		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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *3-5*, 1949, to *3-17*, 1949, that I last saw the deceased alive on *3-17*, 1949, and that death occurred at *1:10* a m., from the causes and on the date stated above.

23a. SIGNATURE Oscar L. Daniels (Degree or title) M. D.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 3-17-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/19/49		24c. NAME OF CEMETERY OR CREMATORY St. Peter's	
				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. MAR 18 1949		REGISTRAR'S SIGNATURE J. B. Sauter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Russell Und., Co. 2732 Pine Blvd.	

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

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 _____

WILLIAM M. BROWN

Student Embalmer No. 272

working under my personal supervision.

Signed William M. Brown
Student Embalmer

Signed

Clark Young

Licensed Embalmer No. 3371

P. O. Address St. Louis

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.