

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 04523

FILED DEC 6 1949

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 04523

1. PLACE OF DEATH a. COUNTY <u>St. Louis, Mo.</u> <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Richmond Heights</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Harrisburg</u>	
c. LENGTH OF STAY (In this place) <u>8 days</u>		d. STREET ADDRESS (If rural, give location) <u>106 E. Collins St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>SAM</u> b. (Middle) c. (Last) <u>JONES</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 26, 1949</u>		
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5. SEX <u>M</u> <u>W</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>Nov. 16, 1949</u>		9. AGE (In years last birthday) <u>10</u> IF UNDER 1 YEAR: Months Days Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Harrisburg, Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
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13a. FATHER'S NAME <u>James B.</u>		13b. MOTHER'S MAIDEN NAME <u>Lucille</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>James Buck Jones, Harrisburg, Ill.</u>	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		<u>Terminal Bronchopneumonia</u>				<u>9 days</u>	
DUE TO (b)		<u>Pneumothorax, right</u>				<u>1 day</u>	
DUE TO (c)		<u>Numerous congenital abnormalities of lower intestinal</u>				<u>7 1/2</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION <u>11/17/49; 11/25/49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Urinary tracts</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 11/17, 1949, to 11/26, 1949, that I last saw the deceased alive on 11/26, 1949, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Francis J. Burns, M.D.</u>		(Degree or title)		23b. ADDRESS <u>4660 Maryland St. Louis 8 Mo.</u>		23c. DATE SIGNED <u>11/27/49</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>11-27-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Harrisburg, Ill.</u>	
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DATE REC'D BY LOCAL REG. <u>11-28-49</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Womke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>	
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed

Albert G. Hopper

Licensed Embalmer No. 2971

P. O. Address _____

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.