

FILED MAR 7 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6276

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1960

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis 2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. STREET ADDRESS (If rural, give location) 512 Cornum St.	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Jones c. (Last) Jones	4. DATE OF DEATH (Month) (Day) (Year) 2 26 51
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5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 0	8. DATE OF BIRTH 5-22-1900	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Tom Jones	13b. MOTHER'S MAIDEN NAME Millie Douglas	14. NAME OF HUSBAND OR WIFE Single
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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) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Pearlina Jones 512 Cornum St.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis Generalized Arteriosclerosis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Lt. Hemiplegia		

19a. DATE OF OPERATION 1/2	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4
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22. I hereby certify that I attended the deceased from 2-14, 19 51, to 2-26, 19 51, that I last saw the deceased alive on 2-26, 19 51, and that death occurred at 8:55 A.M., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) Alvin J. Thompson M.D.	22b. ADDRESS 2601 Whittier	22c. DATE SIGNED 2-27-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 3-3-51	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis MO
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 28 1951 J. B. Forster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gustowe 2930 Dickson St.
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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 _____

William G. Lowe

Student Embalmer No. *399*

working under my personal supervision.

Student *William G. Lowe*
Student Embalmer

Signed *Leroy W. Bannister*

Licensed Embalmer No. *4523*

P. O. Address. *3880 Easton 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.