

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10265

FILED MAR 19 1951

1003 State File No. 1974

|   |  |  |   |  |   |  |  |
|---|--|--|---|--|---|--|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>318</u>  |   | PRIMARY REG. DIST. NO. _____   |   | Registrar's No. _____  |  |
| 1. PLACE OF DEATH<br>a. COUNTY  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u> |   |  |  |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>   |  | c. LENGTH OF STAY (in this place)  |   | c. CITY (If outside corporate limits, write RURAL and give township) <u>Salem</u>  |   | 0331   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>   |  |  |   | d. STREET ADDRESS (If rural, give location)  |   |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Willie</u>   |  |  | b. (Middle) <u>Lee</u>                                |  | c. (Last) <u>Jones</u>  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 27, 1951</u> |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>                                  | 8. DATE OF BIRTH <u>Sept. 17, 1900</u>                |  | 9. AGE (In years last birthday) <u>50</u>                       | IF UNDER 1 YEAR Months _____ Days _____  | IF UNDER 24 HRS. Hours _____ Mins. _____                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Potosi Tie &amp; Lbr. Co.</u>                                     |   | 11. BIRTHPLACE (State or foreign country) <u>Gladden, Mo.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |
| 13a. FATHER'S NAME <u>William A. Jones</u>  |  | 13b. MOTHER'S MAIDEN NAME <u>Sarah Rhodes</u>  |   | 14. NAME OF HUSBAND OR WIFE <u>Myrna</u>   |   |  |  |
| 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>Unknown</u>   |   | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Myrna Jones</u> ADDRESS <u>Salem, Mo.</u>  |   |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.         | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Sabralachoid Hemorrhage</u><br><br>ANTECEDENT CAUSES<br>DUE TO (b) <u>Cause and manner of same could not be determined</u><br>DUE TO (c) <u>Open Verdict</u><br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Open Verdict</u> |  |   |  |   | INTERVAL BETWEEN ONSET AND 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) <u>5:45</u>   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR? <u>Box</u>  |   |  |  |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:45</u> p.m., from the causes and on the date stated above. |  |  |   |  |   |  |  |
| 23a. SIGNATURE (Degree or title) <u>Patric E. Taylor, Colonel</u>   |  |  |   | 23b. ADDRESS <u>1300 Clair</u>   |   | 23c. DATE SIGNED <u>2-28-51</u>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>  |  | 24b. DATE <u>2-28-51</u>   | 24c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove</u> |  | 24d. LOCATION (City, town, or county) (State) <u>Salem, Mo.</u> |  |  |
| DATE REC'D BY LOCAL REG. <u>FEB 28 1951</u>   |  | REGISTRAR'S SIGNATURE <u>J. B. Lanier</u>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>   |   |  |  |

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 Me

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis Mo

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.