

FILED SEP 22 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31876**
8032

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN West Frankfort 8/24	
c. LENGTH OF STAY (In this place) 2 8 days		d. STREET ADDRESS (If rural, give location) 605 So. Short	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) MARY	b. (Middle) LUELLA JENKINS	c. (Last) STARK	4. DATE OF DEATH (Month) (Day) (Year) 9 9 1951
-------------------------------------	------------------------	-----------------------------------	------------------------	---

5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER 2	8. DATE OF BIRTH 6/5/1880	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
----------------------	-------------------------------	---	----------------------------------	---	------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Illinois 1	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	-----------------------------------	---	--

13a. FATHER'S NAME Benjamin Frank	13b. MOTHER'S MAIDEN NAME June Ann Smith	14. NAME OF HUSBAND OR WIFE
--	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Jess Kelle - West Frankfort.	ADDRESS
--	-------------------------	---	---------

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis, pulmonary		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis, general.		5 yrs +

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.	21e. (INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 163X
--	---	--

22. I hereby certify that I attended the deceased from **3/31/1949**, to **9/9, 1951**, that I last saw the deceased alive on **9/9**, 19**51**, and that death occurred at **11:45 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William M. Jewell M.D. U	23b. ADDRESS 5600 Arsenal St.	23c. DATE SIGNED 9/9/51
--	--------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-10-51	24c. NAME OF CEMETERY OR CREMATORY DENNING	24d. LOCATION (City, town, or county) (State) West Frankfort Ill.
---	--------------------------	---	--

DATE REC'D BY LOCAL REG. SEP 10 1951	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	ADDRESS
---	---	--	---------

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

08-11-11

STATEMENT BY LICENSED EMBALMER

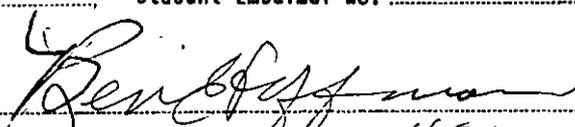
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 4366

P. O. Address Paris 5240

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.