

FILED OCT 23 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35229

State File No. ....

8722

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8722**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair</b>	
b. CITY OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (in this place) <b>4 Wks</b>	c. CITY OR TOWN <b>East St. Louis</b> <b>8720</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Mary's Infirmary</b>		d. STREET ADDRESS (If rural, give location) <b>1619 Kansas</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Ray</b> b. (Middle) c. (Last) <b>Jones</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct 1 1951</b>
----------------------------------------------------------------------------------------------------------	------------------------------------------------------------

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Jan 2, 1907</b>	9. AGE (in years last birthday) <b>44</b>	10. UNDER 1 YEAR Months	11. UNDER 1 HR. Hours	12. UNDER 1 MIN. Min.
--------------------	-------------------------------	-----------------------------------------------------------------------	-------------------------------------	-------------------------------------------	-------------------------	-----------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Armour &amp; Co. DUSTRY</b>	10b. KIND OF BUSINESS OR IND. <b>Co. St. Louis, Ill</b>	11. BIRTHPLACE (State or foreign country) <b>Bohvia, Penn.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
----------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------	----------------------------------------------------------------	-------------------------------------------

13a. FATHER'S NAME <b>Charlie Jones</b>	13b. MOTHER'S MAIDEN NAME <b>Cornelia Robinson</b>	14. NAME OF HUSBAND OR WIFE <b>Elizabeth Jones</b>
-----------------------------------------	----------------------------------------------------	----------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>	16. SOCIAL SECURITY NO. <b>365-14-4297</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Elizabeth Jones</b>	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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Nephrosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>
	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. <b>Hypertension</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>None</b>	20. AUTOPSY? YES <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>H/LX</b>
-------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------------------

22. I hereby certify that I attended the deceased from **June 1, 1951**, to **Oct 1, 1951**, that I last saw the deceased alive on **10/1, 1951**, and that death occurred at **11 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. Mackson, M.D.</b> (Degree or title)	23b. ADDRESS <b>100 E. Perry, East St. Louis, Ill</b>	23c. DATE SIGNED <b>10/15/51</b>
----------------------------------------------------------	-------------------------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>2 Oct 1951</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Brooklawn Washington</b>	24d. LOCATION (City, town, or county) (State) <b>E. St. Louis, Ill</b>
-------------------------------------------	-----------------------------	----------------------------------------------------------------	------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <b>OCT 3 1951</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. S.</b>	ADDRESS <b>2114 Missouri St. St. Louis, Ill</b>
--------------------------------------------	-------------------------------------------------	--------------------------------------------------	-------------------------------------------------

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

*Separate Emb Cert filed*

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.....

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.