

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39209
Registrar's No. 9894

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. 1005

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

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo. b. COUNTY St. Louis

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

d. FULL NAME OF HOSPITAL OR INSTITUTION _____

d. STREET ADDRESS (If rural, give location) 1380 Blackstone

3. NAME OF DECEASED
a. (First) John b. (Middle) Jones c. (Last) Jones

4. DATE OF DEATH (Month) (Day) (Year) 10-20-57

5. SEX Male 6. COLOR OR RACE Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 1872

9. AGE (In years last birthday) 79

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME _____

13b. MOTHER'S MAIDEN NAME _____

14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME ADDRESS J. E. Taylor 1300 Clark

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
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diffuse Generalized Peritonitis
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma Colon Splenic Flexure
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH _____

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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) 153X

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

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 7:27 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) _____

23b. ADDRESS 1300 Clark

23c. DATE SIGNED 11/15

24a. BURIAL, CREMATION, REMOVAL (Specify) _____

24b. DATE 11/8 1957

24c. NAME OF CEMETERY OR CREMATORY Anatomical Board

24d. LOCATION (City, town, or county) (State) _____

DATE RECEIVED BY LOCAL REG. _____

REGISTRAR'S SIGNATURE _____

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service 4104 Manchester Ave.

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.....

Students of Mortuary College

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *James A. Summers*

Licensed Embalmer No. *4142*

P. O. Address *St Louis*

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.