

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43061

State File No. 11737  
Registrar's No. 11737

FILED JAN 16 1952

BIRTH NO. 00225-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1005

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (If deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY 2119	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS, MO.		c. CITY (If outside corporate limits, write RURAL and give township) MINTOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS MATERNITY HOSPITAL		/d STREET ADDRESS (If rural, give location) 4206 WEST BELL PLACE	

3. NAME OF DECEASED (Type or Print) a. (First) <i>Infant</i> b. (Middle) c. (Last) JONES	4. DATE OF DEATH (Month) (Day) (Year) 12-21 51
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5. SEX MALE 21	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NO 11	8. DATE OF BIRTH 12-20-51	9. AGE (In years last birthday) 24	10. MONTHS 5	11. BIRTHPLACE (State or foreign country) ST. LOUIS, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U S A
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) ST. LOUIS, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME JOHNNIE E. JONES	13b. MOTHER'S MAIDEN NAME HATTIE FRANCIS ALTHOUSE	14. NAME OF HUSBAND OR WIFE NONE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS JOHNNIE & HATTIE JONES 4206 WEST BELL PL.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>primary atelectasis</i> ANTECEDENT CAUSES DUE TO (b) <i>prematurity</i> 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
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 162.5
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22. I hereby certify that I attended the deceased from 12-20-51, 19, to 12-21, 1951, that I last saw the deceased alive on 12-21, 1951, and that death occurred at 5:00A. m., from the causes and on the date stated above.

23a. SIGNATURE <i>M. Bondurko MD</i> (Degree or title)	23b. ADDRESS 630 S. Kingshighway Blvd.	23c. DATE SIGNED 12-22-51
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE JAN 2 1952	24c. NAME OF CEMETERY OR CREMATORY <i>Anderson Board</i>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. JAN 2 1952	REGISTRAR'S SIGNATURE <i>Carl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Houlston Mortuary Service</i>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....

Student Embalmer

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.