

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

33086

State File No.

1952 OCT 1

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8549**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri 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 St. Louis, 2179	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 17 3848 Cleveland 6	

3. NAME OF DECEASED (Type or Print) a. (First) Nora T. b. (Middle) Jones c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Sept. 9, 1952					
5. SEX white	6. COLOR female	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec. 6, 1879	9. AGE (In years last birthday) 72	# UNDER 1 YEAR Months	# UNDER 1 MTH. Days	# UNDER 1 HR. Hours	# UNDER 1 MIN. Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY?		

13a. FATHER'S NAME John Roach		13b. MOTHER'S MAIDEN NAME Catherine Flynn		14. NAME OF HUSBAND OR WIFE Frank A. Jones Sr.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Frank A. Jones Sr. 3848 Cleveland	

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) myocardial failure		INTERVAL BETWEEN ONSET AND DEATH 2 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease		
	DUE TO (c) Diabetes mellitus		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Virus pneumonia?			3 days

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) 9:00 9-9-52 12 m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 260X
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22. I hereby certify that I attended the deceased from **July 1850**, to **9-9-1952**, that I last saw the deceased alive on **9-9-1952**, and that death occurred at **2250** m., from the causes and on the date stated above.

23a. SIGNATURE Arthur K. Trisler M.D. (Degree or title)	23b. ADDRESS 3604 Washington	23c. DATE SIGNED 9-10-52
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 9-12-52	24c. NAME OF CEMETERY OR CREMATORY St. Peters Cem.
		24d. LOCATION (City, town, or county) (State) Kirkwood, Mo.

DATE REC'D BY LOCAL REG. SEP 11 1952	REGISTRAR'S SIGNATURE Charles Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Southern Funeral Home 6322 S. Grand Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Mr. Carl Reis,

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 David Hau Fossan.

Licensed Embalmer No. 4243

P. O. Address 6322 Le Grand.

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.