

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40359

DEC 12 1952

State File No.

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 10629

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4311 Maffitt Avenue		d. STREET ADDRESS (If rural, give location) 4311 Maffitt Avenue	
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) S. c. (Last) Jones		4. DATE OF DEATH (Month) (Day) (Year) 11/15/52	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 2/24/1890
9. AGE (In years last birthday) 62		10. MONTHS 9	11. DAYS 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Crawford, Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Abb Rhodes		13b. MOTHER'S MAIDEN NAME Evelyn Hughes	
14. NAME OF HUSBAND OR WIFE Ernest Jones		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Frank Jones, 1718 Carr Drive	
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) = Congestive Heart Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) = Hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) (Min.)		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 443x		22. I hereby certify that I attended the deceased from May 1950 , to 11-15-1952 , that I last saw the deceased alive on 11-15-1952 , and that death occurred at 8:00 m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Walter A. Young M.D.		23b. ADDRESS 2335 Market Street	
23c. DATE SIGNED		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 11/20/52		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates, 4107 Finney Avenue	
DATE REC'D BY LOCAL REG. NOV 19 1952		REGISTRAR'S SIGNATURE J. Earl Smith M.D.	

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

STATEMENT BY LICENSED EMBALMER

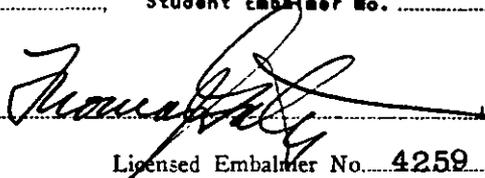
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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.