

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

43534

State File No.

11472

FILED JAN 10 1953

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

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 Illinois b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR Mitchell 8120 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital | | d. STREET ADDRESS (If rural, give location) Rural Route 8 | |

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|---|------------------------------|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) CLARENCE b. (Middle) c. (Last) JONES | | 4. DATE OF DEATH (Month) (Day) (Year) 12 11 52 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) M | 8. DATE OF BIRTH 10-10-1901 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk | | 10b. KIND OF BUSINESS OR INDUSTRY railroad | 11. BIRTHPLACE (State or foreign country) Missouri |
| 13a. FATHER'S NAME unknown | | 13b. MOTHER'S MAIDEN NAME unknown | 14. NAME OF HUSBAND OR WIFE Alice Jones |

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|---|--|--|--|
| 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 ADDRESS Alice Jones, Mitchell Ill. | |
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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, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Perforation of ileum DUE TO (c) Lymphosarcoma II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition | | |

| | | |
|---|--|---|
| 19a. DATE OF OPERATION 12/8/52 | 19b. MAJOR FINDINGS OF OPERATION Lymphosarcoma of ileum perforation & widespread peritonitis | 20. AUTOPSY? YES <input checked="" 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? 2001 |

22. I hereby certify that I attended the deceased from **12/8 1952** to **12/11 1952**, that I last saw the deceased alive on **12/11/52**, ~~10-~~, and that death occurred at **8 A** m., from the causes and on the date stated above.

| | | | |
|---|-------------------|-------------------------------------|-------------------------------------|
| 23a. SIGNATURE Richard J. Sisson M.D. | (Degree or title) | 23b. ADDRESS Jewish Hosp. | 23c. DATE SIGNED 12/11/52 |
|---|-------------------|-------------------------------------|-------------------------------------|

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|---|------------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 12-12-52 | 24c. NAME OF CEMETERY OR CREMATORY Granite City, Ill. | 24d. LOCATION (City, town, or county) (State) |
|---|------------------------------|---|---|

| | | |
|--|--|---|
| DATE REC'D BY LOCAL REG. DEC 12 1952 | REGISTRAR'S SIGNATURE J. C. Smith M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hodge F.H., Granite City, Ill. |
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m J B I (Licensed Embalmers' Statement on Reverse Side)

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.....

Ronald O. Yalinski

Signed.....
Student Embalmer

Licensed Embalmer No.....

3917

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.