

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3312**
Registrar's No. **0981**

FILED FEB 11 1953

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BIRTH NO. <u>91255</u>		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.		
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. LENGTH OF STAY (In this place) 21 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2119		
d. FULL NAME OF HOSPITAL OR INSTITUTION Romer G. Phillips				d. STREET ADDRESS (If rural, give location) 11 3858 Evans				
3. NAME OF DECEASED (Type or Print) Oliver			a. (First)		b. (Middle)		c. (Last) Jones, Jr.	
4. DATE OF DEATH 1 19 53		4. DATE OF DEATH (Month) (Day) (Year)		5. SEX Male		6. COLOR OR RACE Negro		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0		8. DATE OF BIRTH 12-29-52		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min. 21		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY?		
13a. FATHER'S NAME Oliver Jones		13b. MOTHER'S MAIDEN NAME Bertha Jackson		14. NAME OF HUSBAND OR WIFE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT'S SIGNATURE OR NAME <i>Arthur M. Sheward</i>		ADDRESS RR 2601 N. Whittier		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> Broncho Pneumonia				INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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? 7635				
22. I hereby certify that I attended the deceased from 12-29-1952 , to 1-19-1953 , that I last saw the deceased alive on 1-19-1953 , and that death occurred at 2:25 a. m. , from the causes and on the date stated above.								
23a. SIGNATURE <i>W. H. Smith</i>		(Degree or title) M. D.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 1-21-53		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 1-31-53		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL REG. JAN 28 1953		REGISTRAR'S SIGNATURE <i>J. C. Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service		ADDRESS 4184 Manchester Ave.		

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. _____

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.