

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7678**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1769**

FILED MAR 11 1953

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. LENGTH OF STAY (in this place) 48 Hrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2269	
3. NAME OF DECEASED a. (First) Winfield b. (Middle) H. c. (Last) Jones		4. DATE OF DEATH (Month) (Day) (Year) Feb. 15, 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 14, 1914
9. AGE (In years last birthday) 38		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	
10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (City and State or Foreign Country) Oklahoma	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Harry Jones		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Mrs. Louise Jones
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) Yes W.W. 2nd		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Louise Jones, 1523 1/2 Destrehan Street
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) Depressed fracture of skull ANTECEDENT CAUSES suffered skull fracture by a 2x4 during altercation over Tavern at 2700 W. 9th St. they are Michael & wedding about 130 am Feb 13 1953	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Justifiable Homicide	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. PLACE OF INJURY (e.g., home, hotel, factory, street, office building, etc.) Tavern	
21b. TIME OF INJURY (Month) (Day) (Year) (Hour) Feb 13 53 12:30		21c. HOW DID INJURY OCCUR E983X	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. (City, town, or township) (COUNTY) (STATE) St Louis Mo	
22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>134A</u> m., from the causes and on the date stated above.			
23a. SIGNATURE John E. Seyle		23b. ADDRESS 1300 Olive	
23c. DATE SIGNED 2/16/53		23d. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens,	
23e. BURIAL, CREMATION, REMOVAL Removal		23f. LOCATION (City, town, or county) (State) Wellston, Mo.	
24a. DATE REC'D BY LOCAL REG. FEB 16 1953		24b. REGISTRAR'S SIGNATURE J. Carl Smith	
24c. FUNERAL DIRECTOR'S SIGNATURE Mrs. Math Hermann & Son Inc.		24d. ADDRESS 2161 E. Fair Ave.	

(Licensed Embalmer's 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Allen W. Day

Licensed Embalmer No. 3737

P. O. Address St. Louis, Mo.

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.