

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15849**  
**3488**

FILED APR 18 1953

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place)		2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>4318 Fairfax</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Mary</b> b. (Middle) c. (Last) <b>Jones</b>	4. DATE OF DEATH <b>March 31 1953</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 23, 1900</b>	9. AGE (In years last birthday) <b>52</b>	10. IF UNDER 1 YEAR Months <b>8</b>	11. IF UNDER 1 MIN. Hours <b>8</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Sedalia, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Oscar Jones</b>	13b. MOTHER'S MAIDEN NAME <b>Missouri Henderson</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Devolia Jones libbs</b>	ADDRESS <b>4318 Fairfax</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardinoma of Breast with Generalized Metastasis</b>	ANTECEDENT CAUSES <b>Metastasis</b>		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	DUE TO (b) _____		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>170x</b>

22. I hereby certify that I attended the deceased from **2-20 1953**, to **3-31 1953**, that I last saw the deceased alive on **3-31 1953**, and that death occurred at **7:05p m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Thomas Brewer M. D.</b>	23b. ADDRESS <b>2601 N. Whittier St.</b>	23c. DATE SIGNED <b>4-1-53</b>
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24a. BURIAL - CREMATION REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>4-2-53</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>Sedalia, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>APR 2 1953</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D. E. B. Keane</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>1221 N. Grand</b>	ADDRESS
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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 *C. Cream*

Licensed Embalmer No. 4755

P. O. Address 12212 Lehigh

**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.