

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15851**
Registrar's No. **4221**

FILED MAY 14 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4445 Ashland		e. STREET ADDRESS (If rural, give location) 10 4445 Ashland 2109	

3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) c. (Last) Jones			4. DATE OF DEATH (Month) (Day) (Year) April 21, 1953		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 6, 1895	9. AGE (15 years last birthday) 57	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Forrest City, Ark.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Dan Jones	13b. MOTHER'S MAIDEN NAME Katherine Johnson	14. NAME OF HUSBAND OR WIFE Willie Mae 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. 499-10-1044	17. INFORMANT'S SIGNATURE OR NAME Willie Mae Jones	ADDRESS 4445 Ashland
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Lungs		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? 163X
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22. I hereby certify that I attended the deceased from **4-10**, 19**53**, to **4-21**, 19**53** that I last saw the deceased alive on **4-16**, 19**53**, and that death occurred at **8:30** m., from the causes and on the date stated above.

23a. SIGNATURE K. A. Hill, MD (Degree or title)	23b. ADDRESS 1417 Franklin Ave.	23c. DATE SIGNED 4-23-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE April 24 1953	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. APR 24 1953	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE English Und. Co.	ADDRESS 1123 N. Taylor
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Wallace R. Williams*

Licensed Embalmer No. *4926*

P. O. Address *4587 Ladington*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.