

FILED JUN 20 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 22922
5641
Registrar's No.

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 5641	
1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Illinois</i> b. COUNTY <i>St. Clair</i>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis</i>		c. LENGTH OF STAY (in this place) <i>3 wks.</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>East St. Louis 9/20</i>		d. STREET ADDRESS (If rural, give location) <i>1049 North 39th Street 8</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Jewish Hospital</i>							
3. NAME OF DECEASED (Type or Print) a. (First) <i>LOTTIE</i>		b. (Middle) <i>MAY</i>		c. (Last) <i>JONES</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>6 5 53</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>M</i>		8. DATE OF BIRTH <i>February 11, 1909</i>	
9. AGE (In years last birthday) <i>44</i>		IF UNDER 1 YEAR Months <i>3</i> Days <i>24</i>		IF UNDER 6 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>McClecken County, Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Bert Stone</i>		13b. MOTHER'S MAIDEN NAME <i>Billie Page</i>		14. NAME OF HUSBAND OR WIFE <i>Floyd E. Jones</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Mr. Floyd E. Jones 1049 N. 39th St. East St. Louis, Ill.</i>			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pulmonary edema & congestion</i> ANTECEDENT CAUSES DUE TO (b) <i>ileo-vaginal fistula</i> DUE TO (c) <i>Carcinoma of Cervix</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Dead kidney left</i>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <i>6/4</i>		19b. MAJOR FINDINGS OF OPERATION <i>Inoperable carcinoma of cervix; ileo-vaginal fistula</i>				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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>171X</i>			
22. I hereby certify that I attended the deceased from <i>May</i> , 1953, to <i>June</i> , 1953, that I last saw the deceased alive on <i>6/5</i> , 1953, and that death occurred at <i>7:15 P.M.</i> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>Richard G. Sisson MD</i>				23b. ADDRESS <i>Jewish Hosp.</i>		23c. DATE SIGNED <i>6/5/53</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24b. DATE <i>6/6/53</i>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <i>East St. Louis, Illinois</i>	
DATE REC'D BY LOCAL <i>JUN 6 1953</i>		REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>John Karsky East St. Louis, Ill.</i>			

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.....

Pat Embalsmed

working under my personal supervision.

Student Embalmer No. *Name*

Signed.....
Student Embalmer

Name

Signed.....
Licensed Embalmer No. *4162*

Joseph Kasaly

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.