

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33504

State File No.

FILED OCT 15 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9028**

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. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 3636 Page	

3. NAME OF DECEASED (Type or Print) Joseph	a. (First)	b. (Middle)	c. (Last) Jones	4. DATE OF DEATH (Month) (Day) (Year) 9 17 53
--	------------	-------------	---------------------------	---

5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Dec 28, 1889	9. AGE (In years last birthday) (Specify) 64	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	Min.
-----------------------	----------------------------------	---	---	--	---------------------------	-------------------------	---------------------------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Okla.	12. CITIZEN OF WHAT COUNTRY? USA.
---	--	--	---

13a. FATHER'S NAME Joseph Jones	13b. MOTHER'S MAIDEN NAME Carry Johnson	14. NAME OF HUSBAND OR WIFE None
---	---	--

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.	17. INFORMANT'S SIGNATURE OR NAME Willoughby Jones	ADDRESS 4223 St Louis Ave
---	-------------------------	--	-------------------------------------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) renal		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Rural Insufficiency		Undt.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 450.0
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **8-18**, 19**53**, to **9-17**, 19**53**, that I last saw the deceased alive on **9-17**, 19**53**, and that death occurred at **12:08Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E. B. Williams, M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 9-17-53
---	---	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-21-53	24c. NAME OF CEMETERY OR CREMATORY Oakdale	24d. LOCATION (City, town, or county) (State) St. Louis County MO
---	-----------------------------	--	---

DATE REC'D BY LOCAL REG. SEP 18 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Boyd Bros Funeral Home	ADDRESS 3706 Finney 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.....
Signature of Student Embalmer

Signed *Henry C. Williams*
Licensed Embalmer No. *498*

P. O. Address *1205 Wal*

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.