

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45372

State File No.

FILED JAN 19 1954

318

REG. DIST. NO. PRIMARY REG. DIST. NO. 1003

Registrar's No. 12363

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		e. STREET ADDRESS (If rural, give location) 2099 9 1450 E. Warne Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) MINNIE		b. (Middle) JEFFERSON	
c. (Last) JEFFERSON		4. DATE OF DEATH (Month) (Day) (Year) Dec. 29 1953	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Nov. 17 1877
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Heintz		13b. MOTHER'S MAIDEN NAME Not Known	
14. NAME OF HUSBAND OR WIFE Louis A. Jefferson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Hazel Russell		ADDRESS 1450 E. Warne	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis		years.	
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS		General senility	
Conditions contributing to the death but not related to the disease or condition causing death.		years.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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?		331X	
22. I hereby certify that I attended the deceased from June 1950 to Dec. 29, 1953 that I last saw the deceased alive on Dec. 29, 1953 and that death occurred at 4:30 p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) D. Zirkle Eck M.D.		23b. ADDRESS 508 N. Grand	
23c. DATE SIGNED Dec. 3, 1953			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1 2 54	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. DEC 31 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Buchholz Koeller 5967 W. Florissant	

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.....

Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.