

FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

13626

BIRTH NO. 25926-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3595

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, MISSOURI c. LENGTH OF STAY (In this place)
c. CITY OR TOWN ST. LOUIS d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSPITAL
e. STREET ADDRESS (If rural, give location) 26 3517a North Broadway 2269

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last)
JONES
4. DATE OF DEATH (Month) (Day) (Year)
APRIL 1, 1954

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 8. DATE OF BIRTH April 1, 1954 9. AGE (In years last birthday) 9 9 9

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

13a. FATHER'S NAME Clarence Jones 13b. MOTHER'S MAIDEN NAME Lucy Lloyd 14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Hospital Record ADDRESS

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) Congenital atelectasis INTERVAL BETWEEN ONSET AND DEATH 9 hrs
*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
DUE TO (b) Prematurity
DUE TO (c) Section delivery - mother's uterus ruptured
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 NO

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)
762.5

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-1-54, 19 , to 4-1-54, 19 , that I last saw the deceased alive on 4-1-54, 19 , and that death occurred at 9:04 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Elizabeth K. Gay M.D. 23b. ADDRESS 1515 Lafayette Avenue 23c. DATE SIGNED 4-2-54

24a. BURIAL, CREMATION, REMOVAL (Specify) 24b. DATE 4-30-54 24c. NAME OF CEMETERY OR CREMATORY Anatomical Board 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. APR 21 1954 REGISTRAR'S SIGNATURE J. Carl Smith MO 25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service ADDRESS

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.