

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29011**
7284

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

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. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS 1314 N. Taylor		(If rural, give location) 21190	

3. NAME OF DECEASED (Type or Print)	a. (First) Dan	b. (Middle)	c. (Last) Jones	4. DATE OF DEATH (Month) (Day) (Year) July 31, 1954
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 30, 1913	9. AGE (In years last birthday) 40	IF UNDER 1 YEAR Months 8 Days 1	IF UNDER 18 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operate Crane		10b. KIND OF BUSINESS OR INDUSTRY Scullen Steel		11. BIRTHPLACE (City and State or Foreign Country) Arcola, Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Dave Jones	13b. MOTHER'S MAIDEN NAME Virginia Myles	14. NAME OF HUSBAND OR WIFE Separated
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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. Unk.	17. INFORMANT'S SIGNATURE OR NAME Isaiah Hill	ADDRESS 1705 No. Sarah
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undt
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular Accident		
	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"/>

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 July 14, 1954, to July 31, 1954, that I last saw the deceased alive on July 31, 1954, and that death occurred at 2:45 Pm., from the causes and on the date stated above.

23a. SIGNATURE E. B. Williams	(Degree or title) M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 8/2/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE August 7, 54	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. AUG 5 1954	REGISTRAR'S SIGNATURE Wm. Smith	25. FUNERAL DIRECTOR'S SIGNATURE Wm. Smith	ADDRESS 4019 Washington
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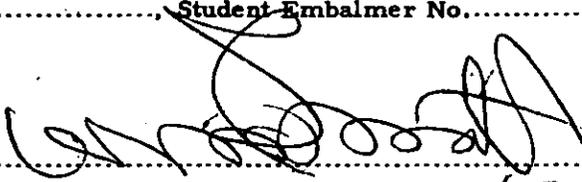
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

We have no record of an accident. Will - insurance

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. 43.....

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.