

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29013**  
**7640**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <b>St. Louis.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <b>St. Louis</b>		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 <b>Homer G. Phillips Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>27 1110 N. 19th</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Elizabeth</b>		b. (Middle) _____		c. (Last) <b>Jones</b>		4. DATE OF DEATH (Month) <b>8</b> (Day) <b>13</b> (Year) <b>54</b>	
5. SEX <b>Female</b> <b>3</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>7-28-1919</b>	
9. AGE (In years, last birthday) <b>35</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Will Malone</b>			13b. MOTHER'S MAIDEN NAME <b>Arlivia Badger</b>			14. NAME OF HUSBAND OR WIFE <b>John Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <b>Arlivia Malone 3719<sup>e</sup> Cass</b>		ADDRESS	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Tuberculous Meningitis</b>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>	
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 (Specify) <b>SUICIDE HOMICIDE</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR? <b>010x</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		21g. _____	
22. I hereby certify that I attended the deceased from <b>8-9</b> , 19 <b>54</b> , to <b>8-13</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>8-13</b> , 19 <b>54</b> , and that death occurred at <b>8:35 A m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Joseph Ebron</b>				23b. ADDRESS <b>M.D. 2601 N. Whittier</b>		23c. DATE SIGNED <b>8-13-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>Aug 19/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Worthington Park Cem St Louis</b>		24d. LOCATION (City, town, or county) (State) <b>MO</b>	
DATE REC'D BY LOCAL REG. <b>AUG 18 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F. W. Green 4214 Delmar</b>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *F. A. Green*.....

Licensed Embalmer No. *296*.....

P. O. Address *4214 Delmar*.....

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.