

FILED SEP 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **30351**BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 874

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Pennsylvania b. COUNTY Allegheny							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, S. Campbell Twp.		c. LENGTH OF STAY (In this place) 2 mos. 28 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pittsburgh		d. STREET ADDRESS (If rural, give location) Unknown					
d. FULL NAME OF HOSPITAL OR INSTITUTION Medical Center for Federal Prisoners				8370 9							
3. NAME OF DECEASED (Type or Print) a. (First) Leroy			b. (Middle) (None)		c. (Last) Jones		4. DATE OF DEATH (Month) (Day) (Year) Sept. 18, 1954				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married		8. DATE OF BIRTH Aug. 8, 1899		9. AGE (In years last birthday) 55 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 12 HRS.: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant			10b. KIND OF BUSINESS OR INDUSTRY Parking Lot		11. BIRTHPLACE (State or foreign country) Florida			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Obie Jones			13b. MOTHER'S MAIDEN NAME Margaret (?) Jones			14. NAME OF HUSBAND OR WIFE -----					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME FILE:M.C.F.P., Springfield, Missouri					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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inanition				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of lung with metastasis				DUE TO (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.											
19a. DATE OF OPERATION June 21, 1954		19b. MAJOR FINDINGS OF OPERATION: Tumor of lung.						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) _____		163X					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 May 22 , 19 54 , to Sept. 18 , 19 54 , that I last saw the deceased alive on Sept. 18 , 19 54 , and that death occurred at 10:25 p. m. , from the causes and on the date stated above.											
23a. SIGNATURE E.C. Rinck (Degree or title) E.C. RINCK, M.C., Clinical Director						23b. ADDRESS Medical Center for Federal Prisoners, Springfield, Mo.		23c. DATE SIGNED 9-20-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9/21/1954		24c. NAME OF CEMETERY OR CREMATORY Pittsburgh, Pennsylvania		24d. LOCATION (City, town, or county) (State) Springfield, Mo					
DATE REC'D BY LOCAL REG. 9-24-54		REGISTRAR'S SIGNATURE Edith Williamson			25. FUNERAL DIRECTOR'S SIGNATURE Harvey Cope			ADDRESS Springfield, Mo			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING INK—NEVER USE PENCIL OR ERASER—PERMANENT RECORD

OCT 1 1954

STATEMENT BY LICENSED EMBALMER

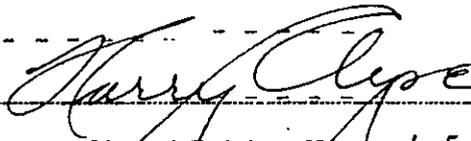
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____



Licensed Embalmer No. 4594

P. O. Address Springfield, Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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