

FILED SEP 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31924**
Registrar's No. **8196**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY None		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. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 33 Yrs.		e. STREET ADDRESS (If rural, give location) 21 1922a Cole	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G. Phillips Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Nannie	b. (Middle) _____	c. (Last) Jones	4. DATE OF DEATH (Month) (Day) (Year) 9 3 54
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 11, 1891	9. AGE (In years last birthday) 63	# UNDER 1 YEAR Months _____	# UNDER 1 YEAR Days _____	# UNDER 1 HRS. Hours _____	# UNDER 1 HRS. Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Vicksburg, Mississippi		12. CITIZEN OF WHAT COUNTRY? U. S. A.		

13a. FATHER'S NAME Sam Gaston	13b. MOTHER'S MAIDEN NAME Lula Ellis	14. NAME OF HUSBAND OR WIFE James Jones
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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) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Joe Sherrod, 2223a Cole, St. Louis, Mo.	ADDRESS _____
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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, ashenia, 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) Hypertensive Cardiovascular Disease with Decompensation; Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. External Hemorrhoids			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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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? 443X
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22. I hereby certify that I attended the deceased from **7-7**, 19**54**, to **9-3**, 19**54**, that I last saw the deceased alive on **9-3**, 19**54**, and that death occurred at **12:02A m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph E. Brown M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 9-4-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Sep. 11, 54	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County
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DATE REC'D BY LOCAL REG. SEP 7 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Cunningham-Moore Funeral Home	ADDRESS 2405 Marcus Ave.
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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.....
John Cunningham

Licensed Embalmer No. 447

P. O. Address 4700 Ha

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.