

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9781

State File No.

FILED MAR 31 1955

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2395

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	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) <u>1- Day</u>		e. STREET ADDRESS (If rural, give location) <u>6750 Odell Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Incarinate Word Hospital</u>		3. NAME OF DECEASED a. (First) <u>John</u> b. (Middle) <u>W</u> c. (Last) <u>Jockens</u>	
4. DATE OF DEATH <u>March 16, 1955</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 5, 1875</u>	
9. AGE (In years last birthday) <u>79</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Electrician</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Jockens</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Katherine</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>490-12-1361</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Katherine Jockens</u> ADDRESS <u>6750 Odell St.</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> <u>5 yrs</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Congestive Failure</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input 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) _____	
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? <u>4200</u>		22. I hereby certify that I attended the deceased from <u>April</u> , 1954, to <u>March</u> , 1955, that I last saw the deceased alive on <u>15 March</u> , 1955, and that death occurred at <u>9:02</u> m., from the causes and on the date stated above.	
23a. SIGNATURE <u>Rosemary R. Jarkin M.D.</u> (Degree or title)		23b. ADDRESS <u>3284 Dwan Ave</u>	
23c. DATE SIGNED <u>16 March 1955</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>3-18-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Matthew</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		DATE REC'D BY LOCAL REG. <u>MAR 16 1955</u>	
REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Connelly</u> ADDRESS <u>3840 Lindell Blvd.</u>	

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 *Francis Williamson*.....

Licensed Embalmer No. *356*.....

P. O. Address *3840 Le...*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fail 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.